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Vol. 15. No. 9

SEPTEMBER, 1958

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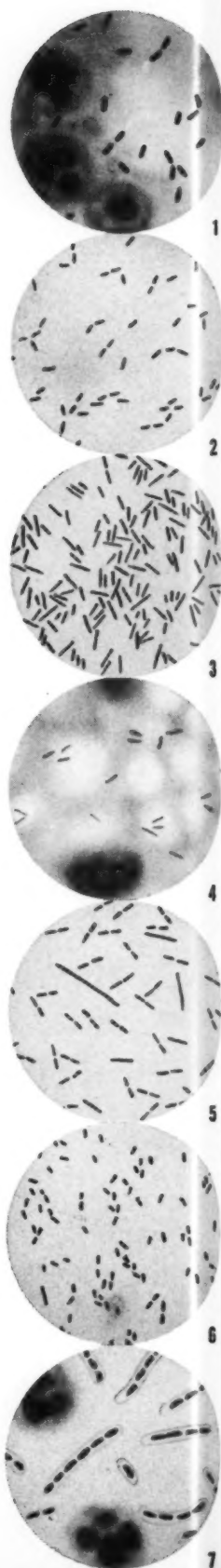
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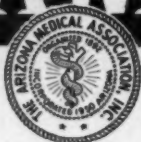


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Original Articles

THE CYTOLOGY AND TREATMENT OF CARCINOMA OF THE UTERINE CERVIX*

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FOR SOME TIME there has been an interest in factors which might have a prognostic influence in the management of patients treated for carcinoma of the uterine cervix. This has been especially true in regard to the application of radiation therapy as the primary treatment modality. Obviously such an interest becomes important because of the desire to improve results of treatment. If the significance of variations in biologic factors inherent in the tumor or in the host herself can be ascertained, there is the possibility that they might be modified toward improvement in radiation reactions and eventually improved survival rates.

Quite naturally it is difficult to assess such factors in mathematical terms and to evaluate them from a statistical point of view. One can hardly speak of "invasiveness" of a tumor without referring to "host resistance" or vice versa. Moreover, it is impossible to analyze the results of treatment without referring to the amount and type of treatment applied in terms of the patient material at risk. Despite such difficulties inherent in the clinical evaluation of treatment, the aforestated desire to improve results continues to stimulate therapists toward critical analyses of their methods. Since these are clinical problems, most of these studies are retrospective in nature and are subject to variations in interpretation, but this does not detract from their necessity.

This discussion will concern itself with some

of our experiences in relation to an interest in factors which might influence prognosis in patients treated for carcinoma of the cervix uteri by radiotherapeutic means. Some years ago, a study was made of such factors and the usual conclusions were reached; namely, the condition of the host as measured by the age of the patient had no prognostic influence, nor did the character of the tumor as measured by its histologic grade(2). The factor most influential in terms of outcome of treatment appeared to be the advancement of the tumor itself in terms of the gross clinical staging, which was to be expected. It is probable that this factor overshadowed the others which could be measured and recorded. It is also quite probable that local secondary infection and generalized debility associated with secondary anemia do lend themselves toward a poorer prognosis, but enough data were not available to study these specific phases. However, these factors have been analyzed by others and are important in that they can be controlled by antibiotics, transfusions, and dietary regimes(12).

Prognostic Influence

In our study, we did find that the amount of treatment delivered had a definite prognostic influence but in a paradoxical fashion. In patients who had advanced lesions, the results were better with high parametrial dosage, but in patients with early lesions, the results became poorer with high parametrial dosage. This concept of the deleterious effect of over-dosage was not new

*From the Los Angeles Tumor Institute.
The cytologic work is supported by the Damon Runyon Cancer Fund.

and had been described some 17 years ago by the late Dr. Margaret Tod, of Manchester (14). She named this finding the "supralethal effect" and attributed the deleterious effects of overdosage to an excessive destruction of the normal tissues adjacent to the cervix in the parametrial triangle at the crossing of the ureter and uterine artery.

This concept of too much radiation as well as too little being of prognostic significance has led to studies of optimal dosage. The nature of radiation therapy necessitated analyses of time of delivery as well as doses delivered to specific areas in the parametrium for patients classified within specific gross stages of the disease. It was found that in patients with advanced stages of the disease, the doses delivered to the lateral parametria had to be above a certain minimal level before clinical cures would result. Conversely, in patients with early lesions confined to the cervix, treatment failures began to appear after certain maximal doses were delivered to the proximal parametrium. There seemed to be a range of dosage throughout the tissue at risk in the pelvis which was associated with optimal results (13). Findings similar to these were found by Garcia (4) and others (1,3), which further indicated the effect of the treatment applied upon prognosis.

In recent years, our interest has been in the application of this theoretical concept of optimal dosage, since the amount of treatment is the one factor having a bearing upon prognosis which is under the direct control of the therapist. Since 1952, when the 1,000-curie Cobalt 60 teletherapy unit became available to us, we have tried to apply these ideas concerning optimal dosage di-

rectly upon our clinical material. Various analyses of early results have been made which indicate a fairly satisfactory adherence to levels of dosage which should be "adequate." However, there continue to be failures even in early cases, despite the availability of megavoltage apparatuses. This has led to a continued interest in measurable biologic differences which might account for such failures.

Grahams et al.

Along these lines, the cytological work of the Grahams (6,7,8) has been most fascinating. In studying vaginal smears, they noted certain measurable changes in the character of the normal vaginal cells exfoliated after radiation therapy, which they described in 1953 as RR (or radiation response). These were qualitatively recognizable by an increase in cell size, increase in nuclear size, and vacuolization of the cytoplasm. They found that the recognition of this RR effect could be reproduced by other observers in their laboratory and could even be reduced to a mathematical term as an average normal cell size. These changes were directly correlated with results of treatment by radiation therapy. Further, they described an ability to change a poor RR to one of satisfactory levels by the administration of testosterone, progesterone, or alpha-tocopherol during treatment.

Similar changes were noted in the exfoliated cancer cells in the vaginal smear, which included increase in cell size, cytoplasmic vacuolization, and deeper staining nuclei, but these could not be measured during the entire treatment, since cancer cells were prone to disappear from the smear.

S. B. Gusberg (11) has made similar observa-

CARCINOMA OF THE CERVIX UTERI

Patients Treated with Cobalt 60 plus Radium, 1954 to 1957.

Relationship between SR and clinical result of treatment.

	SR ≤ 7 per cent		SR 8 per cent - 10 per cent		SR ≥ 11 per cent	
	SUCCESS	FAILURE	SUCCESS	FAILURE	SUCCESS	FAILURE
ALL STAGES	38 (95 per cent)	2	6	4	20 (61 per cent)	13
	SR ≤ 9 per cent		SR ≥ 10 per cent			
	SUCCESS	FAILURE	SUCCESS	FAILURE		
STAGE I	21	1	11	2		
STAGE II	16	2	7	6		
STAGES I & II	37 (92 per cent)	3	18 (69 per cent)	8		

tions on tissue sections from cervical biopsies during treatment. Special staining for nucleoproteins has shown changes in the cancer cells themselves, which are associated with the destruction of the RNA which is a precursor to cellular death and, in itself, a radiation response.

Glücksman(5), in England, has approached this problem of radiation response in terms of a differentiation of tumor on a histologic basis rather than a cellular one.

The Grahams have carried their work further and have described a distinctive feature in the vaginal smear by which they can prognosticate whether a tumor will respond before treatment is given. This lies in the proportionate number of a certain type of normal benign basal cell in the vaginal smear. This cell is called the SR (or sensitivity response) and is described as being the same size as other basal cells, but containing finely granular cytoplasm, taking a lavender stain rather than a pale blue. There are cytoplasmic vacuoles with red granules about their periphery, and the nucleus may be slightly larger than the usual basal cell. They have found that if these cells be less than 10 per cent per 100 benign vaginal cells, the radiation response will be poor. If the proportion of these cells be higher, the response will be good.

Correlations

A study of clinical results correlated with these findings indicated that patients with low SR would do poorly when treated by radiation means, but would do well when treated surgically. Conversely, they showed that patients with a high SR would do well with radiation therapy, but poorly with surgery. Meigs(9, 10) has commented upon this latter feature and has pointed out that in patients treated by surgery for carcinoma of the vulva as well as for carcinoma of the cervix, a higher proportion of lymph node metastases is seen in patients with high SR. He has suggested that the SR may be a measurement of host resistance to lymphatic invasion, and that the poor results from surgery in the face of a high SR are a demonstration of this.

Because of the tremendous importance such findings as these would make upon the management of patients with carcinoma of the cervix, we have tried to reproduce these results.

Since 1954 we have attempted to obtain pre-treatment vaginal smears and repeated weekly smears while the patient is under treatment, as

well as follow-up specimens from one to three weeks and six weeks after the completion of treatment. The smears are obtained as simple vaginal pool aspirations, fixed and stained in the usual manner. Our technician cytologists were trained at the Massachusetts General Hospital to follow the same technique and criteria of evaluation as are used there. The material obtained has been reviewed by a competent pathologist who is interested in cytology.

We have only recently tried to correlate the cytologic findings with clinical results in patients treated primarily by radiation therapy and, in general, have been unable to reproduce the findings reported by the Grahams. There were 83 patients of all stages upon whom adequate cytologic material was obtained for review. When the SR criterion in the pre-treatment smear was used and the patients classified as SR absent (0-7 per cent), SR poor (8-10 per cent) and SR good (11 per cent), we found success rates of 95 per cent, 60 per cent, and 61 per cent, respectively, for each category, which is exactly opposite to the expected result. However, in this group of patients there were five Stage 0 patients which would be considered universally responsive to treatment, and 12 Stage III and IV patients, which are generally unsuccessfully treated. When these are eliminated, there remain 66 Stage I and II patients in whom the individual results of treatment should be variable. In this group, the patients showing 0-9 per cent SR in the pre-treatment smears have been 92 per cent successful to the present time. Those with 10 per cent SR have been only 69 per cent successful.

Further Findings

The RR response in benign vaginal cells was
CARCINOMA OF THE CERVIX UTERI
Stage I and II Patients Treated With Cobalt 60
Plus Radium, 1954 to 1957.

Relationship between disappearance of cancer cells from vaginal smear with cervical dosage and clinical result.

DOSE AT CERVIX	SUCCESS Per Cent	FAILURE
<5,000 r	22 (88)	3
5,100 r		
to	19 (83)	4
7,500 r		
7,501 r		
to	18 (78)	4
10,000 r		

also studied, but only on a qualitative basis, which does not lend itself well to evaluation. An attempt to measure an average cell size is being done, but the data are not as yet complete. Measurements of the increase in average cancer cell size also have been attempted but (as noted by the Grahams) these cells are oftentimes absent in the smears during the later stages of the treatment. However, in reviewing this cytological material from this point of view, it was noted that recognizable cancer cells at times disappeared from the smear even before adequate dosage levels were reached. We found the last positive or doubtful smear to be obtained with doses to the cervix of less than 5,000 r in 25 cases. The last positive smear appeared in 23 cases when the cervical dose was from 5,100 to 7,500 r, and the last positive smear when the cervical dose was from 7,500 to 10,000 r in 18 cases. When these findings were correlated with clinical results, we found only a slight significance, since the success rates were 88 per cent, 83 per cent, and 78 per cent respectively for each category. However, we thought it advisable to attempt to correlate this early disappearance of cancer cells from the smears during therapy with the SR in the pre-treatment smear.

Here, in the theoretically most advantageous situation, when cancer cells were absent after cervical doses of 7,500 r or under, and the SR was 10 per cent or higher, there were six failures in 18 cases, or a success rate of 67 per cent and a failure rate of 33 per cent. In the least favorable situation from a prognostic point of view, when the cancer cells did not disappear until a cervical dose of 10,000 r had been given, and when the SR was 9 per cent or less, there were two failures in 16 cases, or an 88 per cent success rate and a 12 per cent failure rate. This was again in direct divergence from what one would like to see, if we are to attribute prognostic significance to findings in the vaginal cytology.

In summary, it must be said that there can be many reasons for our inability to reproduce data from vaginal cytology upon which a prognosis can be made for patients with carcinoma of the cervix treated by means of radiation therapy. The most likely one is that we are not interpreting the cytologic findings correctly. If this be true, we can say that the method is faulty only because it is difficult for the uninitiated to learn.

We wish to acknowledge the assistance of our cytologic technicians, Mrs. Anita Seleen and Miss Mildred MacMillan, in the preparation of the cytologic material for this presentation.

CARCINOMA OF THE CERVIX UTERI

Patients treated with Cobalt 60 plus Radium, 1954 to 1957

Relationship between SR, disappearance of cancer cells with cervical dosage, and clinical results

LAST POSITIVE SMEAR WITH CERVICAL DOSE	SR ≤ 9 per cent		SR ≥ 10 per cent	
	SUCCESS	FAILURE	SUCCESS	FAILURE
<7,500 r	23	1	12 (67%)	6 (33%)
>7,501 r	14 (88%)	2 (12%)	6	2

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THE CORRELATION OF BRONCHOSCOPIC AND BRONCHOGRAPHIC FINDINGS IN THE MIDDLE LOBE SYNDROME*

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SINCE GRAHAM and his co-workers¹ in 1948 reported on chronic obstructive pneumonitis of the right middle lobe, this condition has been given the name of the middle lobe syndrome. While the majority of the workers are of the opinion that this is a definite clinical entity, a few believe that it occurs in other portions of the lungs. While the actual diagnosis could only be made on the operating table and by pathological findings, a definite diagnosis can be made by the use of bronchoscopy and bronchography.

The middle lobe syndrome originates primarily as a bronchostenosis of the right middle lobe bronchus due to involvement of lymph nodes which surround the bronchus near its origin. If the compression is temporary, no permanent damage results. If the lymph node adeno-

pathy persists, changes in the lung parenchyma occur due not only to the pressure of the lymph nodes, but due to inflammatory changes in the bronchial wall itself. A secondary pneumonitis is commonly seen which leads to bronchiectasis, though if the obstruction is permanent, atelectasis is the result.

X-ray findings show commonly a shadow especially in the right lateral chest films in the area of the right middle lobe. A definite diagnosis of middle lobe syndrome could be made on bronchoscopy and bronchography. Bronchoscopy will reveal varying degrees of inflammation and obstruction of the middle lobe bronchus and secretion which may be thick and blood tinged. Bronchography may show narrowing or complete obstruction of the bronchus, though if the obstruction has been relieved, bronchiectatic

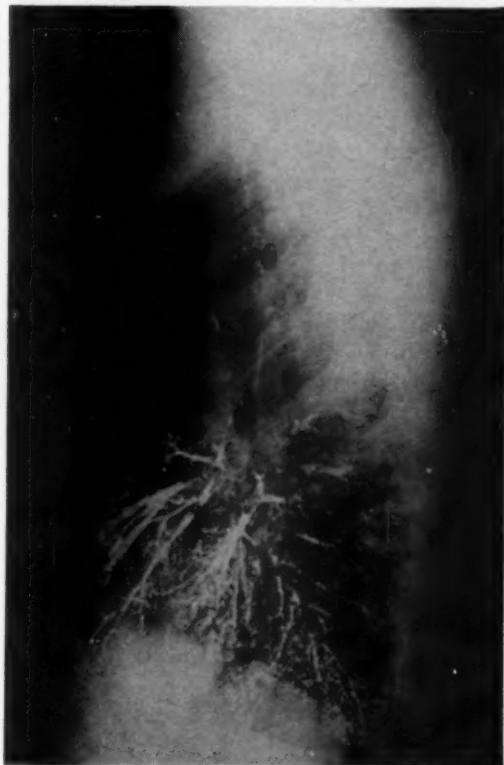


Figure 1



Figure 2

*From the Veterans Administration Hospital, Tucson, Arizona. Presented at the Meeting of the Arizona Chapter, American College of Chest Physicians, May 2, 1958.

changes or close grouping of the bronchi due to atelectasis may be demonstrated.

Combinations of Findings

The 11 cases which have been observed at this hospital illustrate the various combinations of findings which may be seen on bronchoscopy and bronchography. Cases 1, 6 and 10 showed failure of the right middle lobe bronchus to fill at this time of bronchography (Fig. 1) but at bronchoscopy, only Case 6 revealed compression of the bronchus, Case 1 showing injection of the orifice and Case 10 the presence of creamy secretion. Cases 2, 3 and 7 showed evidence of bronchiectasis on x-ray examination (Fig. 2) and at the time of bronchoscopy, all three showed the middle lobe orifice to be injected and containing thick secretion. Cases 8 and 9 showed

injection of the orifice and the presence of secretion on bronchoscopy, but bronchography was not performed. Cases 4 and 5 demonstrated bronchiectasis on bronchography, but were not bronchoscoped. Ten of these cases underwent surgery and all were found to have a destructive process in the right middle lobe. In three of the cases a large mass of lymph nodes compressing the right middle lobe bronchus was found.

Summary

The etiology, anatomy and pathology of the middle lobe syndrome have been reviewed. It has been demonstrated that by means of bronchoscopy and bronchography, a definite diagnosis of this condition can be made prior to surgery.

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Case	Sex	Age	Bronchoscopy	Bronchography	Pathological Report
1.	M	36	Orifice injected	Lobe did not fill	Lobe shrunken and atelectatic
2.	M	39	Orifice injected and secretion present	Bronchiectasis	Atelectasis and bronchiectasis
3.	M	33	Secretion	Bronchiectasis	Atelectasis. Bronchus surrounded by lymph nodes
4.	M	25	None	Bronchiectasis	Atelectasis and bronchiectasis
5.	M	38	None	Bronchiectasis	Bronchiectasis Lymph nodes enlarged
6.	M	32	Orifice compressed. secretion	Lobe did not fill	Bronchiectasis and large mass of lymph nodes compressing bronchus
7.	M	34	Orifice injected and secretion present	Bronchiectasis	Atelectasis and bronchiectasis
8.	M	66	Orifice injected and secretion present	None Atelectasis on x-ray	No surgery
9.	M	41	Thick, blood-tinged secretion	None Consolidation & cavity on x-ray	Abscess
10.	M	32	Creamy secretion	Lobe did not fill	Bronchiectasis
11.	F	28	None	Bronchiectasis	Atelectasis and bronchiectasis

THE ANALYSIS AND TREATMENT OF THE COMMON FOOT DISORDERS*

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THERE ARE many causes of painful feet, but let us confine ourselves to that very commonplace subject, one that is known as a "flat foot" or, should we say in little better educated circles, a pronated foot. But let me diverge and still change it to say that it is a foot that has a forefoot abduction in relation to the rear foot.

The conventional treatment of the pronated foot is one that continues to support the pronation by the use of arch supports and stiff shanks, which competes with gravity and is not corrective. I would like to present for your consideration a physiological approach to this foot problem; a theory which leads to therapy. Also, I shall show you a method of recording the foot so that you will know tomorrow, or a year from now, or anybody else might understand just what is meant by an abducted forefoot and to what degree it is abducted. This method will enable you to make comparisons from time to time to see whether or not you are getting any improvement in that foot, and will indicate to you the therapy for correcting pronation. I think theories are always good that lead to therapy.

In order that we may acquaint ourselves with the foot, I have a specimen which I would like to show you. Let me emphasize just the two factors which I want to show you, namely, that this foot really consists of two parts; a forefoot, and a rear foot. The rear foot consists of the os calcis and its partner, the astragalus. The os calcis is probably the largest concentration of bone for its size than any bone in the bony structure. It was made large and heavy because of the usage that is given this bone. We might say that the rear foot is the landing gear and as we walk, the body weight lands on the os calcis. Because of that weight thrust, this bone is large and heavy and massive, illustrating that our bodies are the results of the stresses we live with.

In the equinus footed animals or quadrupeds, the os calcis is a narrow little bone that seldom touches the ground. Therefore, I want to emphasize again the fact that our bodies are the result of the stresses we live with, and if we can ana-

lyze those stresses intelligently, then we will know how to cope with them and use our bodies efficiently.

The forefoot can be considered the take-off gear. It consists of the mid-tarsal bones, cuboid, scaphoid and cuneiforms, and the five metatarsals with their extensions, the toes. (The plantar surfaces of the ends of the toes are well padded with interlacing fibrous strands, an excellent surface for weight bearing). The purpose of the toes is to add to the length of the foot which increases the functional efficiency of the foot which acts as a lever of the third order. Less effort is needed to lift a weight when the lever arm is longer. Archimedes once said that if he had a lever arm long enough and a fulcrum to rest it on he could lift the world.

Role of the Toes

The toes contribute to the length of the foot when they are plantar flexed. If dorsiflexed, the well padded plantar surfaces of the toes do not get the weight thrust in the take-off in walking. With the toes dorsiflexed the heads of the metatarsals are the take-off points and get the weight thrust. Unfortunately the heads of the metatarsals are not padded well like the plantar surfaces of the ends of the toes. This localized weight thrust on the metatarsal heads results in callosities which are greater over the second and third metatarsal heads, the pressure being greater because the second and third metatarsals are longer. Those toes are more useful and much more effective if they are in the same sagittal plane in which the knee works and therefore we must have a foot position straight ahead, not turned out, otherwise we do not get the full benefit of the take-off point.

Connecting the forefoot with the rear foot is the astragalo-scaphoid joint with its counterpart, the calcaneo-cuboid joint. This junction is one-third the distance from the tip of the heel to the tip of the great toe.

The astragalo-scaphoid joint has a large, rounded or trochlear surface, allowing a great range of motion in either forefoot abduction or forefoot adduction.

The plantar fascia, uniting the forefoot with

*The Audio-Digest Foundation presents a lecture by Dr. Joseph C. Risser, Professor of Orthopedic Surgery at the College of Medical Evangelists.

the rear foot, is attached anteriorly behind the metatarsal heads and posteriorly to the under surface of the os calcis. Acting as a bow string, it aids in maintaining the longitudinal arch of the foot.

With the forefoot adducted, body weight thrust is carried down from the tibia to and through the outer side of the foot which approximates the ground. If the forefoot is abducted, weight thrust comes on the inner side of the foot on the plantar fascia, which is that broad bow string holding the forefoot and rear foot together to form the long arch of the foot. If the integrity of the plantar fascia is poor, as seen in poor health and deficiency diseases, the plantar fascia will stretch and allow the inner side of the foot to approximate the floor. Soft tissues do not thrive under weight thrust. Whereas weight thrust on the outer side of the foot, made possible by an adduction of the forefoot (on the rear foot), is carried down through the ladder-like layer of metatarsal bones. Bones thrive only under weight thrust. Thus the healthy foot is possible when the weight thrust is on the outer side of the foot, that is, with the forefoot adducted on the rear foot.

Inherited Contracture

One deterring factor in our weight-bearing mechanism is the equinus contracture which we inherit, the shortened distance of the soft tissue structures from the os calcis up to the knee, namely the calf muscles and the tendon achilles. We inherit this equinus contracture from our quadrupedal ancestry. The baby illustrates this when he first starts to walk. He will walk on his toes, maybe for hours — maybe for days. Some children do it for two or three years, indicating that they have not yet become true bipeds. They still are quadrupeds.

If that heel cord is short, the heel rises early and the weight thrust of the body is then thrown upon the mid-tarsal area, the astragalus-scapoid junction, allowing stretch of the plantar fascia and abduction of the forefoot. If the plantar fascia does not give way, but remains intact as the body weight is shifted forward over the mid tarsal area to the metatarsal heads, we put a preponderance of weight thrust where it was not designed for much weight-bearing. Nature did not pad those areas well, therefore they callous very easily. But if you will compare the tip of the toe, the fleshy part of the toe and the

metatarsal head, you will find that nature padded the end of the toe with a very thick fibrous tissue, an interlacing fibrous tissue, that can bear weight easily. So we should have our ultimate take-off point on the ends of the toes and not on the metatarsal heads. Now, if we have metatarsal head callouses, which many people have, we must conclude then that we have a short heel cord that contracts early and raises the heel early on the step forward, and thus puts a preponderance of localized weight-thrust upon the metatarsal head. The logical remedy is to stretch out the heel cord.

Unfortunately, as we progress and grow up, we wear shoes. The conventional idea is to put heels on the shoes, which only continues to increase the shortening of this inherited contracture. To avoid this problem of increasing heel cord contracture and also lessen our inherited equinus contracture, our shoes should have little or no heel. Exercises are also designed to stretch the equinus contracture. This equinus stretching becomes a continuous process when walking with little or no heels on shoes. You hear people say they cannot wear a shoe without a heel. Naturally they cannot, because they have not continued to stretch out that contracture. Remember the two great enemies to good body health and good body control are gravity, with which we cannot compete, and our own joint contractures. We can cope with contractures if we know how to take care of them intelligently. Therefore stretching out the heel cord is important.

Heels and Arches

The question has been raised — "Why do we have heels on shoes?" Some people trace the origin of the heel to Napoleon and Louis XIV, who, being short men, wanted to be taller in order to impress their fellow-men. But Alfred Edward Wiggam has a different explanation. He was a biologist who said it was all due to the women. He said women, in a romantic mood, put heels on their shoes so they would not be kissed on the forehead.

Other questions that arise about the foot — "What should be the height of the arch?" "Why do we have an arch in the foot?" "Is it necessary?" There is only one reason why we have an arch in the foot and that is to house the important structures on the bottom of the foot. If we had no housing gear to take care of those nerves and vessels and muscles on the under side of

the foot, we would walk directly on those muscles and vessels. But unprotected vessels do not tolerate weight thrust. Thus we must have a housing mechanism that protects these vital structures under the foot. This housing mechanism is the arch. Now the height of that arch is not significant, just so that it is high enough to house those vital structures, to keep us from walking on our veins and our muscles and our nerves. The essential point is how are we putting weight thrust on that foot? Do we put weight thrust through bone on the outer side of the foot that will actually bear weight and thrive, or do we put it on the soft inner side of the foot that will not bear weight?

Now another factor in regard to the heel on the shoe — as soon as we put a heel on a shoe, we elevate the toes and stretch the plantar muscles, the short flexors on the foot. Let me just demonstrate that by showing you a shoe, the heel of which is very high. In order to get thrust down flat on a flat surface with that high heel the toes must be elevated and in so doing they are stretching out the muscles — the flexor muscles — on the bottom side of the foot, and remember, a stretched muscle is always a weak muscle. If you want to make a muscle strong, give it the mechanical advantage of shortening that muscle; that is a very important principle that we must use in re-educating the polio cases. Frequently we forget that. If you want a strong muscle, shorten it, and if you want a weak muscle, you will weaken it by stretching it. Therefore the high heel again would merely stretch the plantar muscle on the under side of the foot.

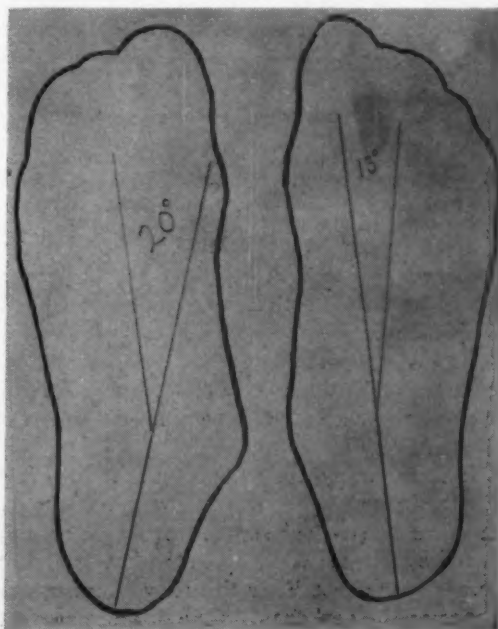
A tracing is made of the natural weight-bearing foot with a pencil that is held perpendicular to the paper on which the patient stands, not dipping down obliquely to get underneath as far as possible, but to reflect the outline of the weight-bearing mechanism of the foot onto this flat surface. In so doing, we may have then a bulge at the astragalus scaphoid area which signifies a predominance of weight thrust on the inner side of the foot. By bisecting the astragalus scaphoid area which is one-third the distance from the tip of the heel to the tip of the toe, bisecting the point of the heel and bisecting the area between the metatarsal heads, lines connecting these bisecting dots are drawn and the angle of abduction or adduction can be measured from these lines. Comparative tracings will

show any progress of the forefoot in illustration. The left foot has a severe abduction of 20 degrees. The right foot has only a 13 degree abduction. Then you might ask, "Why is one foot worse than the other?" They both bear weight. At each step they take, the same amount of body weight comes down on it. Explanation of this difference is based on the anatomical variation in leg length in this particular case illustrated. The longer leg carries the greater equinus contracture, resulting in a greater forefoot abduction.

Weight Distribution

The tracing shows that at the astragalus scaphoid joint, there is a preponderance of weight thrust on the inner side of this foot — less so on the right side. As we look at the feet from behind, we see the left foot showing a greater preponderance of weight thrust on the inner side of the foot. In a corrected position with weight thrust thrown on the outer side, you notice that the person corrects the right one much easier than he does the left one. There is still a small amount of weight thrust on the inner side of the left foot where the tendon achilles can be seen deviating. On the right, the tendon is relatively straight.

When the feet are held corrected, that is, the weight on the outer side of the foot, dorsiflexion is limited. But with the feet incorrect, that is, weight on the inner side of the feet, dorsiflexion



is dissipated in the stretch of the plantar fascia and abduction of the forefoot. Therefore it is quite important that you be able to teach your patient how to stretch his heel cord — to hold the foot so that it allows weight thrust on the outer side of the foot. Then he does actually stretch the heel cord as he exercises.

Tracings of the feet of primitive people who do not wear shoes show an adduction of the forefoot with the body weight thrust placed on the outer side of the foot, where body weight is borne by bones which approximate the ground. Those who walk a great deal will necessarily have broad feet, as the Peruvian Indian who carries 100-pound sacks of cocoa leaves over the Andes mountains. Whereas, the Navajo Indian who rides a Pinto pony will have a less broad foot. In either case, body weight is carried on the outer side of the foot as indicated by an adduction of the forefoot to the rear foot as seen in the foot tracing.

The Mexican primitive, clad in a sandal or hurachi, simulates barefoot walking. His tracing also shows weight thrust on the outer side of the foot as indicated by a forefoot adduction. The inherited heel cord contracture is kept stretched, eliminating equinus of the foot by walking without heels on sandals, or barefoot walking.

The type of shoe which would encourage better feet would be one which simulated barefoot walking. The shank of the shoe which connects the heel of the shoe with the sole should be flexible. The flexible shank would allow adduction of the forefoot at the flexible astragalo-scapoid junction, and weight would be carried through bone on the outer side of the foot.

Shoe Heels

The heel of the shoe should be reduced to a minimum which would allow stretching of the heel cord with each walking step. The ideal heel would be no more than an eighth of an inch, which would be only enough to keep from slipping. With a completely flat walking surface, there would be a tendency to slip in walking in leather soled shoes. This type of heel is termed a friction heel.

If there is any abduction of the foot — flat foot or pronated foot — with weight thrust on the inner side of the heel, the foot should be protected by an adequate raise in the forward inner corner of the heel. From this forward inner corner raise, the heel should slope down to zero on

the outer border of the heel and posteriorly to one-quarter inch of the rounded posterior border of the heel. Because of the angle slope outward and posteriorly, this heel is termed a double angled heel. The forward inner corner of the heel is located at the flexible astragalo-scapoid joint in the foot which is one-third of the distance from the heel of the foot to the toe as measured on the foot tracing.

The directions to the cobbler should be as follows:

1. Remove present heels, or spring heels seen in children's shoes.
2. Remove stiff shank if present in shoe.
3. The inner length of the heel is one-third



the length of the foot tracing.

4. The outer length of the heel is half an inch less, to correspond to the calcaneo-cuboid joint, the counterpart of the astragalo-scaphoid movement.

5. Raise only the forward inner corner of the heel. The usual height of the raise is from three-eighths of an inch to half an inch. It may go up to three-fourths of an inch, or even an inch, in feet with a severe abduction of the forefoot.

Children tolerate the higher raises better than the adults. With the raise only on the forward inner corner of the heel, it must slope to zero on the outer side and posteriorly to zero within one-quarter of an inch from the curved border of the heel.

Foot exercises are invaluable in the improvement of the feet.

1. To teach the adduction of the forefoot known as the sand-scrape walk, this exercise is best done in the bare feet on the carpeted floor. The forward foot is placed at an angle of 45 degrees with the forefoot inverted, toes touching the floor, and the outer border of the foot in contact with the floor.

2. Stretch the equinus contracture, that is, shortness of the calf muscle and heel cord. The body weight is placed on the outer border of the feet. The heels and toes are kept firmly on

the floor — stand two or three feet away from the back of a chair or wall on which the hands rest. Lean forward toward the chair or wall, keeping the heels down on the floor. Gravity pull of the body in leaning forward will stretch the heel cord contracture.

Good Feet Are Possible

3. Heel-toe walking: while bearing the body weight on the rear foot, the heel of the forward foot strikes the ground, with the toes elevated. As the body is carried forward the body weight thrust is transferred from the rear foot to the forward foot, first into the heel then the outer side of the foot and finally the toes. As this occurs, the heel of the rear foot elevates, the knee flexes and is carried forward, leaving only the toes of the rear foot on the ground — which aids in balancing the body on the forward foot. The feet should be kept on the ground as long as possible. The process is continued by repeating the movement in walking. Heel toe walking then becomes a process of rocking forward; the body weight is first on the heel, then into the outer side of the foot, and finally taking off with the toes.

Good feet are possible if one uses the foot physiologically, which is only possible with a flexible shank shoe with little or no heel. The shoes must be wide enough and long enough for a good take-off on the toes.

Editorial Page

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The Editor sincerely solicits contributions of scientific articles for publication in ARIZONA MEDICINE. All such contributions are greatly appreciated. All will be given equal consideration.

Certain general rules must be followed, however, and the Editor therefore respectfully submits the following suggestions to authors and contributors:

1. Follow the general rules of good English, especially with regard to construction, diction, spelling, and punctuation.
2. Be guided by the general rules of medical writing as followed by the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.
3. Be brief, even while being thorough and complete. Avoid unnecessary words. Try to limit the article to 1500 words.
4. Read and re-read the manuscript several times to correct it, especially for spelling and punctuation.
5. Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.
6. Articles for publication should have been read before a controversial body, e.g., a hospital staff meeting, or a county medical society meeting.
7. Exclusive Publication—Articles are accepted for publication on condition that they are contributed solely to this Journal. Ordinarily contributors will be notified within 60 days if a manuscript is accepted for publication. Every effort will be made to return unused manuscripts.
8. Illustrations—Ordinarily publication of 2 or 3 illustrations accompanying an article will be paid for by Arizona Medicine. Any number beyond this will have to be paid for by the author.
9. Reprints—Reprints must be paid for by the author at established standard rates.

The Editor is always ready, willing, and happy to help in any way possible.

(The Opinions expressed in original contributions do not necessarily express the opinion of the Editorial Board.)

THE WORLD MEDICAL ASSOCIATION

What It Means To The American Physician

It wouldn't take much argument to persuade any of you gentlemen that our profession — and you personally — need a county medical society, a state society and an American Medical Association.

But the point is that we doctors also need the World Medical Association — and that everyone of us should join and support the United States Committee of WMA — the "international voice of organized medicine."

Now, what is the World Medical Association and what does it do for our profession and for you?

Why did the house of delegates of AMA declare, as it did in November 1956, that:

"It is difficult . . . to believe that any physician in the United States, and especially any member of the AMA is not a member of the WMA. With conditions as they are in the world today, we owe it to ourselves and to our children, not only as physicians but also as citizens of this great country of ours, to do everything in our power to keep the spark of freedom in medicine glowing throughout the world. . . ."

And the house of delegates went on to declare that:

"Further expansion of the United States Committee (of WMA) will be necessary if the American viewpoint is to be continually and effectively presented by our spokesmen in the World Medical Association and, through them, before other international bodies, to protect the interests and aims of medicine and the medical profession. . . . Surely, physicians will wish to share in this international effort."

The World Medical Association was born about 10 years ago, out of the desire of the doctors of the free world to perpetuate the international comradeship and professional contacts of wartime. The founders of WMA recognized that the practicing physicians of the world need a strong organization to represent them before other international organizations, such as the United Nations' World Health Or-

ganization, the International Labor Organization and the International Social Security Association, all of which are actively interested in health and medical projects on an international scale.

WMA, AMA, WHO

The founders of WMA recognized that only by uniting with our colleagues in other countries, can we doctors hope to stem the world wide drive toward socialized medicine and maintain the freedoms that physicians everywhere know are basic to good medical practice.

The World Medical Association now has 53 members, comprising the national medical associations of 53 countries throughout the free world. The unit of membership in WMA itself is the national medical association, and the American member of WMA is the American Medical Association. The 53 members of WMA represent, in aggregate, more than 700,000 physicians practicing in every continent in the world.

Some of us confuse the World Medical Association (WMA) with the World Health Organization (WHO) which is an agency of the U.N. As Dr. Louis H. Bauer, secretary general of WMA has put it: The World Medical Association bears the same relationship to the World Health Organization on the international level that the American Medical Association bears to the United States Public Health Service within the U.S.A.

WHO and the USPHS are government agencies, tax-supported, and concerned with public health. WMA and the AMA are voluntary associations, supported by their members, and they represent the views and interests of the practicing physician.

To enable the *individual doctor* to play a direct, personal role in the world affairs of organized medicine, the profession in the United States and in many other leading WMA member countries have formed "supporting committees." The United States Committee of WMA is the largest of these national supporting committees, now numbering some 5,000 leading American physicians among its members.

American doctors have been almost uniquely fortunate so far, in having met our most pressing socio-economic problems by voluntary action, thus repulsing the threat of political domination of our practice in the U.S.A. But this good fortune only emphasizes our responsibility to take the leadership in defending the prin-

ciples of good medical practice wherever they are attacked and in helping our colleagues in other countries restore these principles wherever they have been compromised.

The solidarity and unity of doctors throughout the free world that has been achieved and given a voice by the WMA has been a big factor in the successful battles that our colleagues in several of the European and Asian countries have fought against various forms of state medicine.

What It Is — What It Does

WMA has set up a standard of 12 principles that must be observed in any acceptable program of medical care under social security — and this is proving to be a rallying point for our colleagues in many countries.

WMA has established an international code of medical ethics, and a modified Hippocratic Oath defining our universal ideals and obligations as physicians. WMA has successfully defended the rights of our profession against recent attempts by certain non-medical organizations to draft a code of international medical law.

WMA has taken the leadership in the field of medical education, having sponsored the first world conference on medical education, held in 1959 in Chicago.

WMA is acting to bring about a freer flow of proved therapeutic agents by urging removal of unwarranted trade restrictions and arbitrary licensing requirements in certain countries. It is trying to aid medical research by promoting national pharmacopoeias and by defending the rights of individuals to name new drugs and agents that they have discovered.

WMA has developed an international emblem for identification and protection of civilian doctors engaged in civil defense, and is setting up a central repository of medical records, so that all physicians may be able to preserve their professional identification and credentials in event of war or natural disaster.

WMA is actively promoting international exchanges of medical students and teachers, and arranging lectures and clinical teaching by traveling teams of physicians.

And here are a few of the direct personal benefits that will be available to you as a member of the U. S. Committee of WMA:

1. The privilege of attending the annual

assembly of WMA (to be held this October in Istanbul) with definite status as an official observer for the U. S. Committee;

2. Aid and advice in travel arrangements for attendance at annual assemblies or at other international medical meetings; introductions to professional leaders and colleagues abroad and opportunities for lectures and visits to medical institutions;

3. A subscription to the World Medical Journal, edited by Dr. Austin Smith (who

is the editor of the Journal AMA) and other newsletters and publications of WMA.

4. A membership card and a certificate of membership.

These advantages, plus the opportunity to play an active part in making more articulate the international voice of the medical profession, are yours for an annual membership fee of \$10 in the United States Committee of the World Medical Association.

The objectives of WMA are your objectives.

EDITOR'S NOTES

THE recent Bulletin of the American College of Surgeons, July-August issue, 1958, suggests that the physician is protected when the public is informed about malpractice. At least, this was the comment of lawyers, doctors, hospital administrators and science writers participating in a public forum on malpractice in San Francisco.

The more pertinent comments to come out of this discussion were: "A doctor encounters many more risks than he did 30 years ago . . .".

"... medicine is now a business. . . . The doctor does not spend the time that should be spent in diagnosis."

"... the doctors have a certain amount of control over their insurance companies."

"... the most important reason of all is the fact that the doctors are a close knit organization and refuse to come into court to testify against their brother physicians."

Res Ipsa Loquitur

"... lawyers felt that justice did not prevail under those circumstances. As judges are lawyers, the judges talked to the lawyers, and they decided: something has got to be done about this! What they did was extend a rule of law — the rule that's called *res ipsa loquitur*, or, 'the thing speaks for itself.' It's a rule of law which we don't need a doctor to testify, but they still can get a jury."

"... A physician does not warrant, guarantee or insure a good result; or that he will effect a cure; or even that his treatment will be beneficial. A physician is not an insurer of a patient's life, and he is not an insurer against mishaps or unusual consequences."

"... The courts, by applying the maxim of *res ipsa loquitur*, presumes the physician's guilt and forces him to carry the burden of establishing his innocence. This concept has now been

extended to all surgical mishaps. . . . These new impositions of liability on physicians stem from the conviction of many judges, that a conspiracy of silence exists among medical men."

The court said: "To apply *res ipsa loquitur* in all cases where an unexpected result occurs would hamstring the development of medical science. No medical man would dare to use new procedures, especially in surgery, because if injury resulted, he would be *prima-facie* guilty of negligence."

"... The ordinary jury is completely incompetent to condemn a person for malpractice."

"Doctors should testify where there really is malpractice, and testify with complete honesty."

Attorneys Also At Fault

"... On the other hand, attorneys are also at fault for this situation — perhaps to a greater degree. Many of the suits are based not on the facts, whether there is malpractice, but whether under conditions of sentimental surroundings we can get a verdict."

"... Principle source of the evil is the contingent fee. Attorneys should not get a percentage of the award."

"In any case, the jury should be informed in advance what percentage of the fee the attorney is going to have. That would make a difference, too!"

"The application of *res ipsa loquitur* — that's completely invalid in medical things."

"It's generally recognized in personal injury cases that if the case is settled out of court, the fee is one-third. If the case is filed or tried, it's 40 per cent."

"... One or two others made the broad generalization that malpractice cases are caused by physicians' mistakes. Some of the other causes are greed on the part of the patient, psychotic disturbances, and in some cases, just the feeling on the part of the person that because the result

wasn't what he or she expected, something must have been wrong with the doctor's care."

"... It's a definite policy that nobody is going to pay off as a nuisance in a malpractice case."

"... A recent study by the California Medical Association of the psychological aspects of malpractice, brought out that there are certain

personality traits in people who sue a doctor, and on the other hand, there are some personality traits in doctors who are being sued. So, there is more to it than just the mistakes of doctors!"

"... The threat of malpractice has enormously increased the use of X-rays, particularly in the field of orthopedics."

BOOK REVIEW

A PRACTICAL MANUAL ON THE MEDICAL AND DENTAL USE OF X-RAYS WITH CONTROL OF RADIATION HAZARDS

This 31-page illustrated booklet was sponsored by the American College of Radiology and by the American Dental Association. The text was prepared by Richard H. Chamberlain, M.D., with the assistance of Robert J. Nelsen, D.D.S., and the Commission on Units, Standards, and

Protection of the American College of Radiology. In substance, this booklet is brief, accurate and practical. Anyone handling diagnostic and therapeutic methods of radiation, particularly the non-specialist in these matters, would do as well by himself as by his patient to review this brochure. Copies are available from the American College of Radiology, 20 N. Wacker Drive, Chicago, 6, Ill.

A.J.B.

LETTERS TO THE EDITOR MEDICAL SCHOOL REPORT

Sir:

I ASSUME that you, as editor in chief of *Arizona Medicine*, accept full responsibility for the reprint, "A Medical School for Arizona," by Richard Harvill, appearing in the July issue of our magazine, as well as the paragraph that follows the second asterisk. Why did you publish a reprint which you know to be pure propaganda?

Why was the cost of a two-year medical school at Arizona State College published in *Arizona Medicine* exactly as shown in the Arizona State College formal prospectus? Why have you failed to print the cost of a two-year medical school as published in the University of Arizona formal prospectus? The board of regents, the faculty of the University of Arizona and Arizona State College, and the Phoenix public are informed. Why is this information withheld from our colleagues?

From that *stuff* after the second asterisk in this article, am I to assume that the delegates to the Arizona Medical Association's 1958 annual meeting received this fol-de-rol rather than a copy of the prospectus or a report based on the prospectus that was presented to us by President Harvill and representative members of his faculty? I hope your explanation is that certain University of Arizona boosters and those members of the Arizona Medical Association were guilty only of entering into collusion as a means of stopping the expansion of Arizona State Col-

lege and its bid for recognition as a university, and that President Harvill's choice of words was adopted by the framers of the Arizona Medical Association's resolution because of his superior academic credits.

I await your reply as to the date that I may expect the publishing of the cost figures of the University of Arizona's medical school prospectus. I also await your reply and explanation as to the intent of that *stuff* after the asterisk.

NORMAN A. ROSS, M.D.

Editor's Note: It is rare to be criticized for quoting correctly.

Those individuals who read this publication have undoubtedly noted that material submitted on various aspects of the medical school problem have been published in the *Journal*. This has included material from Arizona State College at Tempe, the University of Arizona, and the Arizona Medical Association. It is not the intent of the editor to present this material in a biased manner. His opinions have been expressed before in editorials which did not include the choice of location of a medical school when the proper time comes for its establishment.

* * *

ENFORCED HOSPITALIZATION FOR DIAGNOSTIC STUDIES

Sir:

A HIGH proportion of today's citizens carry health insurance, available in a wide variety of forms from a large number of companies. Until

recently, most of the plans have provided no benefit payments for diagnostic x-ray or laboratory services unless performed in hospital laboratories and x-ray departments. To qualify for this coverage, beneficiaries have been required to be bona-fide, in-hospital bed patients; evidently in order to limit liability of insuring companies to necessary procedures. However, from this stipulation, unforeseen and undesirable consequences have arisen.

Many patients through thoughtless self-interest have demanded that they be hospitalized for performance of elective diagnostic services. Although sympathetic physicians, to justify hospitalization and the related insurance claims, have had to resort to diagnostic half-truths and other artifices, such practices have been widespread and insurance claims have mounted.

This has led to the creation of an abnormal, ever-increasing demand for more hospital beds and facilities; and has contributed to a steady increase in hospitalization costs and in the cost of health insurance. More far-reaching, however, has been the diversion of ambulatory patients toward the hospitals, which has had an exceedingly injurious effect upon the whole philosophy

of the private practice of medicine.

The private office of the physician is, in the final analysis, the heart and soul of clinical medical practice in the United States. The doctor-patient relationships here established form the basis of our entire free enterprise, fee for service, medical system.

Our hospitals should be built and preserved for sick people who need bed care. The concept of the hospital as a community health center for the care of all private, ambulatory patients by employed physicians is unhealthy and dangerous. Employment of all physicians by hospitals, clinics and health centers is a very short step from employment of all physicians by the government.

The newly available Blue Shield coverage in Arizona for diagnostic services outside the hospital will probably do much to strengthen the position of the private medical practitioner. It seems reasonable also to hope that this step forward may be accompanied by an easing of the demand for hospital beds, and by a corresponding decrease in the costs of hospitalization.

D.E.M.

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PSYCHOSOMATICS: A Series of Five Lectures
edited by Joh. Booij. 125 pages. (1957) Elsevier. \$5.

The possibilities and limitations of psychosomatic medicine are first considered, followed by a discussion of the psychosomatic aspects of syndrome shift and syndrome suppression. Relationships between anthropology, psychosomatic medicine, and organic pathology are weighed. A chapter on psychotherapy in psychosomatic diseases completes the package. The author is with the Free University, Amsterdam.

Stacey's Medical Books, San Francisco, California.

RECENT ADVANCES IN OBSTETRICS AND GYNAECOLOGY
by Aleck W. Bourne, F.R.C.S. and Leslie H. Williams, M.D. 9th ed. 348 pages. Illustrated. (1958) Little, Brown, \$8.

This volume, through nine editions, has been bearing fruit for 32 years. The title is specific and there are large servings of fresh material for anyone interested in either subject.

Stacey's Medical Books, San Francisco, California.

HEART DISEASE AND PREGNANCY
by C. Sidney Burwell, M.D., James Metcalfe, M.D., and Samuel A. Levine. 338 pages. Illustrated. (1958) Little, Brown, \$10.

A thorough and practical description of the differences between the normal and diseased cardiac during the complications of pregnancy is complete, with an extensive bibliography. Recent discoveries in pathologic physiology open the way to modern methods of management.

OBITUARY

JEREMIAH METZGER, M.D.

DR. JEREMIAH METZGER, born Dec. 9, 1877, died May 26, 1958. Such a tombstone epitaph would be sufficient for most of us, but not for Dr. Metzger. "Jerry," as he was affectionately known to many, lived a lot of life between those dates.



Dr. Metzger was of the old school of gentlemen. He was equally at home in the drawing room with his courtly wit and humor as well as in the enjoyment of the more basic aspects of living. The younger men who have not shared in the pleasure of knowing the man, Dr. Metzger, have missed a great deal. His interest in any and everything was boundless — medicine, people, sports — to mention only a few. He was well known in this country from east to west, and not much less known among the older generation of Europeans.

Born in Oak Harbor, Ohio, Dr. Metzger attended Ohio State University, the University of Michigan and graduated from Rush Medical School in 1901. He came to Tucson in 1911 because of his interest in the West and because he had suffered from bouts of osteomyelitis and tuberculosis. He set up offices in the Physicians Building on South Stone Avenue and soon after that, acquired the Witwell Hospital on North First Avenue where he opened Tucson's first private sanatorium for the care and treatment of tuberculous patients. (This institution later became the Methodist Hospital which operated as a general hospital for a number of years.) He was among the first to use pneumothorax in this country, and he made a special trip to Switzerland to learn Rollier's technique in treating extra pulmonary tuberculosis with heliotherapy.

Dr. Metzger joined the Pima County Medical Society shortly after his arrival in 1911. In 1914 he was elected to the office of vice president and served as its president for the year 1915. There were about 30 members in the society in 1915; the meetings were held at the Old Pueblo Club, and the dues were \$8 a year.

While carrying on an active practice, Dr. Metzger found time to travel and study, both in this country and abroad. He studied in Berlin, Vienna and Switzerland, acquiring advanced knowledge in medicine, tuberculosis and psychiatry. He was much interested in sports and witnessed many of the Olympic Games starting in 1904, attending his last one after World War II. He retired from active practice in 1926. Seeing patients took too much time from pursuing his hobbies in medicine and travel.

In 1941, Dr. Metzger took on the job of reorganizing the Arizona State Hospital. This institution, long in ill repute as a "political football," emerged under his direction into the hospital we know as a progressive, up-to-date mental institution. In making these changes, he irritated a lot of people and stepped on a lot of toes, but such was the character of the man. He had a job to do and he did it.

Dr. Metzger belonged to many organizations. He was a member of the Pima County, Arizona, and American Medical Associations; the American Clinical and Climatological Association, and the New York Academy of Medicine. He was a member of the Old Pueblo Club and one of the founding members of the old Country Club.

He entered his second marriage in 1928 to Mrs. Julia Turner, the widow of an army colonel. He and his wife and mother-in-law have lived for many years in a big, comfortable old house on Main Street. He loved having people in for stimulating conversation, good food and drink. It was always a pleasure being invited to his home.

A good, solid citizen has left our midst. He was a pioneer in Arizona medicine, and we are fortunate that he came to this state to live, practice good medicine, and die full of years and memories of deeds well done.

Topics of Current Medical Interest

FEDERAL LEGISLATION RELATED TO THE PRACTICE OF MEDICINE

VA HOSPITALIZATION BILL APPROVED BY VETERAN COMMITTEE

WINDING UP several weeks of hearings on hospitalization, the house veterans' affairs committee on July 30 ordered reported favorably a veterans' administration bill (HR 10028). Coming late in the session, it is not given much chance of passage. However, it could be revived in the next session. Its highlights:

1. Directs VA to operate 125,000 beds for an average daily patient load of 113,000. Present figures are 120,526 operating beds and 111,000 daily load.

2. Writes into law, as first proposed in HR 58, the 10-P-10 form which veterans with non-service-connected illness now sign on entering VA hospitals; it gives their financial status. This section also requires reading to the applicant of the criminal code pertaining to false statements under oath.

3. Requires VA to notify the veterans' affairs committee during a session of congress, and at least 90 days in advance, of any plans to shut down a hospital or other VA facility.

4. VA administrator could refuse to furnish hospitalization to non-service-connected veterans who are eligible under workmen's compensation, industrial accident laws or health insurance plans, if other eligible veterans are waiting for care. The restriction would not apply in emergency cases.

5. Authorizes the administrator to furnish outpatient care for nsc cases where necessary to determine if admission to a hospital is required and where essential to complete treatment incident to hospital care.

VA HOSPITAL CARE LIMITATIONS URGED BY AMA AND AHA

American Medical Association and American Hospital Association want congress to spell out who is entitled to veterans' administration hospitalization. The AMA thinks the basic policy should do this: The best possible care for veterans with service-connected disabilities or illnesses in VA installations; non-service-connected illness, if the veteran is unable to pay for his

care, to be the responsibility of community governments. The AHA suggests a statutory ceiling of 131,000 beds and the closing of unnecessary facilities.

The two organizations testified July 24 before the house veterans' affairs committee which has been holding extensive hearings on VA hospital policies and practices. The day previously, the committee heard from the American Legion, which maintained that the present policy should be continued, i. e. where beds are available, non-service-connected veterans to get VA care when they state they can't afford to pay for private care. Said the legion witness: "... realism and the uncertainties of the future would demand the preservation of the VA system of hospitals."

Dr. Russell B. Roth, chairman of the AMA committee on federal medical services, said the house group should also authorize a serious study by General Accounting Office and VA of the income level of nsc cases, primarily those in general medicine and surgery hospitals. Also, the law should allow VA to investigate indigency claims made by veterans on the 10-P-10 form which they fill out on admission. Dr. Martin R. Steinberg, chairman of the AHA committee on veterans' relations, also proposed: (1) a new federal category of public assistance for indigent veterans with nsc disabilities, (2) a co-ordinating agency in government for proper planning of VA and other hospitals, federal and non-federal, and (3) health insurance coverage for discharged servicemen, with the U.S. underwriting premiums for limited period of time.

JENKINS-KEOGH PASSES HOUSE, NOW IN SENATE FINANCE COMMITTEE

With scarcely a voice raised in objection, the Jenkins-Keogh bill (HR 10) passed the house on July 29 and was sent to the senate finance committee where its fate is uncertain. The long-sought measure allows self-employed professional or business men to set aside 10 per cent of net earnings each year to a maximum of \$2,500, with the tax on that amount deferred until retirement. As many as 7 million persons would benefit. The fight for passage has been spearheaded by the American Thrift Assembly, of which the AMA is a member.

Representative Keogh (D., N.Y.) led the de-

bate for passage. He stressed the bill's voluntary nature and the righting of a tax inequity (employers now may set aside sums in company retirement plans). More than a score of congressmen joined in urging passage; they included Representative Reed (R., N.Y.), ranking minority member of the house ways and means committee and early advocate of a similar bill.

This observation on the bill's merits came from Representative Dennison (R., Ohio): "Self-employed persons generally assume large personal risks. Those in the professions . . . have a tremendous investment in time and money before entering into actual performance of their calling. They must, in their productive years, set aside sufficient funds to take care of themselves in the years when their own human energy and resources have been depleted. It is not unreasonable or unfair to give them the same tax benefit that employed persons enjoy."

Representative Rogers (D., Fla.), pointed out: "Company officials and employees receive benefits from retirement plans which are not counted as income until the money is actually drawn out, and the company counts their contributions to the funds as expenses at the time they pay into the fund."

HEW STUDY OF MEDICAL CARE COSTS FOR AGED, ASKED BY COMMITTEE

The house ways and means committee, which omitted the Forand hospitalization proposal from its social security bill, in its report calls on the secretary of HEW for a study of the various possibilities for financing medical care of the aged. The secretary was instructed to have the study completed by Feb. 1, 1959. The senate finance committee next takes up the social security bill, following house passage.

The ways and means committee told HEW to place special emphasis on the possibility of increasing social security taxes to finance purchase (through private or non-profit organizations) of health insurance which would go into effect upon retirement.

In its instruction to HEW, the committee says it is "very much aware" of the problems in paying hospital and nursing home bills for the aged, and notes that a number of bills had been introduced on the subject, and that some witnesses had emphasized that health insurance is "out of reach" of many older people. Then the commit-

tee report comments:

"Your committee believes, however, that more information on the practicability and the costs of providing this kind of protection through various methods should be available before it entertains any recommendation for legislation on the subject. A study of alternative ways of providing insurance against the cost of hospital and nursing home care for old-age, survivors, and disability insurance beneficiaries should be made.

"The alternatives explored include among other proposals: a pre-payment plan under which persons would, during their working years, pay additional social security contributions which would be used to buy this type of insurance (to take effect when the individual becomes an old-age, survivors, and disability insurance beneficiary) from private and non-profit health insurance organizations; other methods of providing insurance against the cost of hospital and nursing home care under Title II; and any other method which offers reasonable prospects for protecting old-age, survivors, and disability insurance beneficiaries against the cost of needed hospital and nursing home care. The study would include, for each of the several alternatives, an evaluation of (1) cost of the benefits and (2) administrative implications.

"Your committee has asked the secretary of health education, and welfare to conduct such a study and to report the results on or before Feb. 1, 1959. With the results of such a study available, the congress will be in a better position to decide what legislative measures, if any, should then be taken to meet the problem."

With release of the report, AFL-CIO President George Meany said in a statement that the social security bill "merits support," even though labor is disappointed that nothing was done with the Forand idea. But, said Mr. Meany, "this cannot be construed as a decision of the congress to discard this proposal . . . It is by no means a dead issue . . . It will be a live issue as long as the problem remains unsolved, and we intend to urge the adoption of the Forand proposal along with other measures further to improve the system, as soon as the 86th congress convenes next January."

Mr. Meany said the AFL-CIO had hoped that the increases in benefits would be at least 10 per cent. He described the 7 per cent favored by the committee as "hardly equivalent to the increase

in living costs since the last benefit improvements four years ago."

HOUSE APPROVES SOCIAL SECURITY AMENDMENTS

The house has approved a series of amendments to the social security act. In addition to raising basic benefits 7 per cent and increasing the tax rate and tax base, the bill would give the states greater flexibility in use of federal funds for financing the medical care of the aged, the blind, the disabled and dependent children. There would be no distinction between recipient payments and vendor payments.

Under the bill (HR 13549), the state would receive a portion of \$66 multiplied by the number of adult assistance recipients, and from this pool, the state could meet all payments, subsistence and medical. The present law has worked a hardship on some states; those states that have been pooling medical care payments on the first \$60 faced a loss of federal money or a drastic change in their own laws and procedure.

On this issue, the house ways and means committee states: "The separate matching of payments to doctors, hospitals and other suppliers of medical care would be eliminated with the new maximum of \$66 per individual per month covering both the present maximum of \$60 on an individual payment and the \$6 average now provided for payments for medical care of public assistance recipients. Both this provision and the average limitation on money payments will provide greater flexibility to the states in the operation of their programs, and will also eliminate the special problems existing in some states arising out of existing law."

The new bill also authorizes an additional \$288 million for the states under revised formulas for public assistance, which payments come from general tax funds. As at present, the federal government would provide 80 per cent of

the first \$30 on an average to the aged, blind and disabled recipients. The bill would provide from 50 per cent to 70 per cent matching on amounts in excess of \$30 to the new maximum of \$66 on an average basis, depending on the state's per capita income. The poorer states would receive the higher percentage. The higher average maximum will give the states the added funds.

Additionally, U.S. funds for maternal and child health would be increased from \$16.5 million to \$21.5 million, for crippled children services from \$15 million to \$20 million and for child welfare services from \$12 million to \$17 million.

RESEARCH-TEACHING GRANTS BILL TIGHTENED

In reporting out a bill to extend the program of construction grants for medical research facilities, the house commerce committee tightened up a provision that would make the money available also for medical school teaching facilities. The original wording would have allowed grants to multi-purpose facilities (research and teaching) if their "principal contemplated use will substantially further research in the sciences . . ." The committee changed this to read "if their principal use will be for research. . . ." Thus, because their "principal use" would not be "for" research, grants could not be used to construct and equip dining halls, dormitories, etc., at medical schools, although the grants could be used for buildings and equipment that combine research and teaching.

Under the law, \$30 million a year is authorized for research, and the proposed amendment does not increase this total. However, if the bill reaches the senate, there is the possibility it may be amended to raise the authorization, in view of the eligibility of teaching facilities for grants. Then, before much money would be available for teaching plants, a separate appropriation bill would have to be passed.

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LEGISLATIVE BOXSCORE, 85TH CONGRESS, SECOND SESSION

<i>Subject</i>	<i>Bill No.</i>	<i>House</i>	<i>Senate</i>
Public works loans	S. 3497	Debate under way	Passed April 16
Civilian pay (VA doctors)	S. 734	Public Law 85-462, June 20	
Military pay	HR 11470	Public Law 85-422, May 20	
Public health school grants	HR 11414	Public Law 85-544, July 22	
HEW appropriations	HR 11645	Passed March 27	Passed June 20
	S. 2888		
Union health plans	HR 13507	Reported July 28	Passed April 28
Social security	HR 13549*	Passed July 31	
	HR 6874		
Medical school aid	S. 1917	Hearings held	In committee
Research facilities	HR 12876	Reported July 29	
	HR 13254		
Chemical additives	S. 4193	Reported July 28	In committee
Aging conference	HR 9822	Passed July 29	
	HR 10		
Jenkins-Keogh taxes	S. 3194	Passed July 28	In committee
Hill-Burton extension	HR 12628		
Hill-Burton loans	HR 12694	Passed June 26	Passed July 21
	S. 1045		
Civil aviation medicine	HR 4275	In Committee	Hearings held
Civil defense aid	HR 7576	Passed July 15, 57	Passed July 23
Defense reorganization	HR 12541	Passed June 12	Passed July 18
Medicare appropriations	HR 12738	Passed June 5	Passed July 30
Nursing home loans	S. 4035	Subcommittee OK	Passed July 11
Presumption of service	HR 413	Passed July 7	
connection	HR 1143	Passed July 21	
VA hospitalization	HR 10028	Reported July 30	

No Action:

*Medical care for aged (Forand's HR 9467); grants and scholarships for nursing (HR 306); national compulsory health insurance (HR 3764); health insurance pooling (HR 6506 and HR 6507); rehabilitation (HR 10608 and S. 3551).

SENATE LIFTS MEDICARE RESTRICTIONS; ISSUE NOW IN CONFERENCE

The senate, at the request of Senator Knowland (R., Calif.), amended the defense department appropriations bill to eliminate house-imposed restrictions that threatened to wreck the civilian phase of the Medicare program. The Knowland amendments carried by voice vote at a time when the chamber was crowded in preparation for passage of the big defense bill, but only two or three "nays" were heard. The issue now is in the hands of the senate-house conference committee, where a decision is expected shortly.

Under the house restrictions, a \$60 million spending ceiling would be placed on Medicare, although the year's actual cost is estimated at closer to \$100 million, and the defense department would be forbidden to shift other funds to

the Medicare column, or to ask deficiency appropriations. Because of holdover bills and other obligations, only about \$40 million actually would be available, meaning a 60 per cent cut-back in civilian Medicare.

The Knowland amendments restored the total to the original request, \$70.2 million, and also deleted the section that prevented shifting of funds or requests for additional money. During debate, Senator Knowland observed: "If the congress wishes to change the Medicare program, let us do it in an orderly, gradual way. Let us not act to damage the good will built up among service families by this laudable program."

Senator Chavez (D., N.M.), chairman of the senate appropriations subcommittee that supported the limitations, said he would accept the Knowland amendments because the defense department intends to channel more dependents

to military hospitals by: 1. Instructing dependents residing on posts or in nearby government-sponsored housing to use military facilities. 2. Eliminating certain types of care now authorized in civilian hospitals. 3. Possibly increasing charges to dependents for civilian care.

Prior to the senate vote on the Knowland amendments, a personal letter was sent to every senator by Dr. William J. Kennard, acting director of the Washington office of AMA. It listed the consequences of a drastic cutback in civilian Medicare, outlined the issues involved, and cited a defense department study showing that there is no basis for the conclusion that military medical care is less expensive than civilian. At senate and house hearings, military witnesses had claimed that military hospitals were caring for dependents at a substantially lower cost than were civilian hospitals.

Legislative notes: The house has approved a resolution (HR 9822) by Representative Fogarty (D., R.I.), requesting the President to call a White House conference on the problems of the aging by September 1960, and to make grants of up to \$50,000 to each state to help finance similar state conferences prior to the Washington meeting . . . Mrs. E. H. Hedrick of Beckley, W. Va., active in medical auxiliary work and widow of a physician who served in the house for eight years, is a candidate for the Democratic nomination to congress to fill the same seat . . . The senate approved placing in Statuary Hall of the Capitol a statue of the late Dr. Florence Rena Sabin, noted for her research in the lymphatic system and tuberculosis. If approved by the house, it will be Colorado's first statue in the collection; each state is entitled to two.

COMMITTEE VOTES BOOST IN SOCIAL SECURITY

Winding up its many weeks of open hearings and executive sessions on social security, the house ways and means committee voted increases in benefits and taxes, but took no action on the Forand plan for hospitalization under social security, which had been a controversial aspect of the hearings. The provisions, still not publicly announced, are understood to be as follows:

Benefits. An increase of 7 per cent in monthly social security benefits, with a minimum increase of \$3. **Tax Increases.** The first \$4,800 of employment income to be subject to the social security

taxes, instead of the present \$4,200. In addition, the tax rate to be increased in 1959 one quarter of 1 per cent each for employer and employee from the present 2 1/4 to 2 1/2 per cent and the self-employment tax to 3 3/4 per cent from the present 3 3/8 per cent. Also, the schedule of future rate increases was accelerated to the following: 1960 — Employer and employee, 3 per cent, self-employed, 4 1/2 per cent. 1963 — Employer and employee, 3 1/2 per cent, self-employed, 5 1/4 per cent. 1966 — Employer and employee, 4 per cent, self-employed, 6 per cent. 1969 — Employer and employee, 4 1/2 per cent, self-employed, 6 3/4 per cent.

The committee also is expected to recommend increases approximating 7 per cent for the U.S. contribution to public assistance.

APPROPRIATIONS — NATIONAL CANCER INSTITUTE

The house and senate have passed the 1959 appropriation bill. Total appropriations for the National Institutes of Health are \$294,383,000, an increase of about \$83 million over the 1958 figure of \$211 million.

The 1959 figure for the National Cancer Institute is \$75,268,000, an increase of nearly \$20 million on the 1958 figure of \$55,923,000.

Indirect cost allowance was kept at 15 per cent.

It is interesting that this action increasing appropriations should have followed so closely the release on July 14 of the report of the consultants, chaired by Dr. Stanhope Bayne-Jones on the medical research needs of the country. This group of special consultants included Dr. Lowell T. Coggeshall and was appointed last August by Mr. Folsom, secretary of health, education and welfare to take stock of the nation's medical training and research effort.

The report urges that medical research outlays be tripled to about \$1 billion per year by 1970.

CONFEREES VOTE RECORD \$294 MILLION FOR INSTITUTES OF HEALTH

Senate-house conferees July 17 agreed on a budget for the department of health, education, and welfare, including record high appropriations for the Institutes of Health. Approval is expected without change. Here are the major provisions: A total of \$294 million for the Institutes, or 75 per cent more than the house had proposed; \$186 million for the Hill-Burton hospital

construction program in contrast to \$121 million proposed by the house (diagnostic-treatment centers and chronic disease hospitals were cut from the senate's \$20 million to \$7.5 million each, but senate figures were accepted for rehabilitation centers and nursing homes, \$10 million each); \$6.9 million to build a national library of medicine and \$9.6 million to build an office building at NIH. Rounded-off figures approved for the various institutes (in millions of dollars) are: General research, \$29, cancer, \$75, mental health, \$52, heart disease, \$45.6, dental research, \$7.4, arthritis, \$31, allergy, and infectious diseases, \$24, and neurology and blindness, \$29.

AMA RENEWS EFFORTS FOR NURSING HOME MORTGAGE GUARANTEES

The American Medical Association has renewed its efforts to convince congress that proprietary nursing homes should have the benefit of federal mortgage guarantees. Dr. R. B. Robins, who earlier testified before a senate subcommittee, has asked the housing subcommittee of the house banking and currency committee to act favorably on legislation that already has passed the senate.

Dr. Robins pointed out that financing the medical care of the aged was a serious problem, and that one of the answers was the construction of high quality nursing homes where the aged could receive necessary medical care, yet avoid high costs of hospitalization. He reviewed work done by the AMA over the years to improve the medical care of the aged, and explained how the association was participating in the activities of the joint council to improve the health care of the aged. Other members are the American Hospital Association, the American Dental Association, and the American Nursing Home Association.

Earlier, Dr. T. Stewart Hamilton testified that the American Hospital Association approved the idea of U.S. mortgages for proprietary nursing homes, but he raised a number of objections to the senate bill. For one thing, he said such guarantees should be allowed only if the application has been certified by the PHS surgeon general as "in conformity with" the state's requirements for the Hill-Burton hospital construction program. This would mean that guarantees would be granted only after a survey had shown that the community needed the home.

Testifying for the American Nursing Home Association, George T. Mustin explained that the homes handle about 70 per cent of all elderly patients, that they are handicapped in obtaining ordinary mortgages because they are "one-purpose" structures, that they are a community asset because they provide a place where the elderly patient can receive the necessary medical care without paying the high charges hospitals are forced to make. Replying to the suggestion that guarantees be predicated on a survey, he said Hill-Burton type surveys give an unrealistic picture of the number of nursing homes, and that besides, a need would have to exist or the sponsors and private lending agency would not risk money in the venture.

CONSULTANTS PROPOSE \$1 BILLION A YEAR FOR MEDICAL RESEARCH

The nation should treble its expenditures for medical research and double its output of physicians in the next 12 years, in the opinion of an advisory committee that has just made its report to Secretary Folsom. Chairman of the group was Dr. Stanhope Bayne-Jones, former Yale medical dean and former head of the joint administrative board of New York Hospital-Cornell Medical Center. Other members were medical educators and research directors in private industry.

The report proposes that the U.S. supply about half the research funds, or half a billion dollars by 1970, with the rest coming from industry and private philanthropy. U.S. now pays about 56 per cent of medical research costs. Between 14 and 20 new medical schools should be built, partly to supply needed researchers, and some of them should be started immediately. The consultants believe dangers of federal control of research can be avoided through vigilant and sustained application of safeguards.

SUPREME COURT RULES AGAINST FTC ON INSURANCE

The Federal Trade Commission has lost ground in its campaign against accident and health insurance advertising. The supreme court in a unanimous decision held that FTC has no jurisdiction over such advertising in states that have their own laws on the subject—even though such laws are not being enforced. Cases on the subject had been appealed by the American Life Convention, the Life Insurance Association of America, and the Health Insurance Association of America. The law authorizes federal regula-

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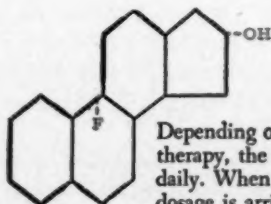
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tion in this area only where states have not entered the field. FTC argued that in this instance the states with regulatory laws were not applying them. The court pointed out that the states in question have prohibitory legislation and that failure on their part to enforce it was not sufficient ground to use federal law.

EYE FOUNDATION AND AMA DISAGREE WITH OPTOMETRISTS

The National Foundation for Eye Care and the American Medical Association are opposing a proposal of the American Optometric Association to authorize optometrists to make examinations for blindness in all government programs. Following testimony by the optometrists to the house ways and means committee, both professional groups sent letters to Chairman Wilbur Mills. The foundation repeated the argument that every time a person is declared blind by an optometrist alone, a chance is lost to determine the true medical cause of the blindness and to appraise chances of rehabilitation or cure.

The issue came before the ways and means committee because it now is considering changes in the social security law, which authorizes optometrists to determine blindness in public assistance cases. AMA also urged that for the protection of patients this authorization be dropped.

STATE UNIVERSITIES OPPOSE NUCLEAR INSURANCE

Twenty-three universities in 18 states are backing legislation to exempt them from buying liability insurance for nuclear reactors. A joint atomic energy subcommittee held hearings July 9 on several bills introduced to ease the Atomic Energy Commission requirements for state schools. In some cases, witnesses said, changes in state constitutions to allow schools to get such insurance would take two or three years. Major bill on the subject is HR 13190 by Representative Melvin Price (D., Ill.). State medical schools would be involved in some states. An AEC official testified that as yet it had no policy on the bill, which is still before the budget bureau.

PHS TO RELEASE MORE INFORMATION ON SMOKING-CANCER ISSUE

Releasing a report showing a high correlation between heavy smoking and high death rates among 200,000 veterans, public health service indicated that from now on it will issue more information on the controversial subject. In line

with the policy, PHS supplied copies of the complete report to all state and territorial health officers as well as to the press. The report, which does not include clinical or laboratory research, was prepared with the co-operation of the veterans' administration, but that agency did not participate in its drafting nor does it sponsor the report. Some of the findings:

1. When adjustments are made for age distribution, the death rate is 32 per cent higher among smokers than non-smokers; deaths varied with the amount smoked, but only in cases where large amounts of tobacco were consumed were rates for cigar and pipe smokers significantly higher than for non-smokers.

2. Cigaret smokers had the highest death rate among tobacco users — 58 per cent higher than among non-smokers; the lung cancer rate for "cigaret only" smokers was 10 times that for non-smokers.

3. For regular cigaret-only smokers, the death rate from coronary heart disease was 63 per cent higher than for non-smokers.

CIVIL DEFENSE EXPANSION BILL GETS SENATE GROUP APPROVAL

The civil defense expansion bill that has been hanging fire for a year (it was passed last July by the house) has received a favorable report from the senate armed services committee. It provides funds to help the states in their civil defense planning and training. The senate committee set specific ceilings on various programs and limited funds to a five-year period. Some examples: No more than \$25 million a year in grants for civil defense personnel and administrative expenses, and \$35 million for radiological instruments.

Leo A. Hoegh, director of the Office of Defense and Civilian Mobilization, told the committee that passage of the bill would "do much to convince the public that the federal government means business . . . and is serious about civil defense." He said the most significant provision in the bill is for federal grants up to 50 per cent of state and local personnel and administrative expenses. By and large, he said, state and local governments on their own have not been able to establish and support proper staffs.

Groups backing the legislation (HR 7576) include the American Municipal Association, the American Legion, the AFL-CIO, National Association of County Officials.

DR. HALDEMAN HEADS HILL-BURTON PROGRAM

The man who will direct the government's multi-million dollar Hill-Burton hospital construction program is Dr. Jack C. Haldeman, who helped organize the program more than 12 years ago. He has been serving as deputy chief of the public health service division of hospital and medical facilities. When Hill - Burton was launched in 1946, Dr. Haldeman was executive officer and had an important part in developing regulations and operating procedures and organizing the field staff. Dr. Haldeman succeeds Dr. Vane M. Hoge, who has been appointed executive director of the Hospital Planning Council of Chicago.

INCOME TAX GUIDE* PERSONAL EXEMPTIONS AND DEPENDENTS

Personal Exemptions — A taxpayer is allowed an exemption of \$600 for himself. In addition, citizens and residents of the United States who are 65 or over by the end of the taxable year, qualify for another \$600 exemption. For tax purposes, a taxpayer is considered to be 65 on the day before his 65th birthday. Still another exemption of \$600 is allowed for blindness, based on the condition on the last day of the taxable year. If a joint return is filed, in addition to his own exemption or exemptions, a taxpayer may claim a personal exemption of \$600 for his wife, an additional exemption of \$600 if she attained the age of 65 by the end of the taxable year, and a third exemption of \$600 if she was blind at the end of the taxable year.

Dependents—An exemption of \$600 is allowed for each person who is dependent upon the taxpayer, if the following five tests are met:

TEST 1 — GROSS INCOME

Generally, a person may not be claimed as a dependent if he has received gross income of \$600 or more for the year. This gross income test does not apply in the case of a child, stepchild, or legally adopted child who is under age 19 or who is a full time student at an educational institution with a regular faculty.

Example: Gordon, a medical student, earned \$1,200 during the year, all of which was spent for his support. His father contributed \$1,300 toward his support. His father may claim him as a dependent, even though Gordon had over \$600 gross income, if the other tests are met.

*Prepared by the law department, AMA.

TEST 2 — SUPPORT

During the taxable year, the taxpayer must have contributed more than half of the support of the dependent, except in a case where there is a "multiple support agreement" (explained later). Support includes amounts expended for board, lodging, clothing, cost of education, medical and dental care, cost of entertainment, and cost of travel and transportation. It does not include amounts spent to purchase capital items (other than clothing).

Scholarships: Amounts received as scholarships for study in an educational institution by a child, stepchild, or legally adopted child who is a student, should not be taken into account in determining the total cost of his support. However, amounts received by veterans for tuition payments and allowances while attending school and appointments to the United States Military Academy or other service academies are not considered scholarships.

Example: During 1957, Dr. Hall's son John, over 19, attended college. He received \$990 from the government, under the GI Bill, to assist him in his education. During the summer he worked and earned \$750. Dr. Hall contributed \$1,500 toward John's support. The fact that the \$990 received from the government for his education is not included in John's gross income does not prevent such amount from being included in the computation of the total amount expended for his support. If the entire \$990 was expended for John's support, Dr. Hall may not claim him as a dependent since he did not contribute more than one-half of John's support. However, suppose John spent \$1,000 for an automobile. Since this amount is not considered as having been spent for his support, Dr. Hall would have met the support test, and if the other tests are met, he may claim John as a dependent.

Multiple Support Agreement: An exception to the support test is made if no one person contributes more than half the support of an individual, but over half of the support of the individual is contributed by two or more persons each of whom, but for the support test, would be entitled to claim the individual as a dependent. In this situation any one (but only one) of the persons who furnished over 10 per cent of the support may claim an exemption for the dependent individual. Each person contributing to the support, except the person claiming the exemp-

tion, must file a written statement that he will not claim the individual as a dependent for that year. The statements should be filed with the return of the person who does claim the exemption. Copies of Form 2120 may be obtained for this purpose from any district director of internal revenue.

TEST 3 — MEMBER OF HOUSEHOLD

If the claimed dependent is a member of the taxpayer's household and lives with him for the entire year, it is not necessary that he be related to the taxpayer in any way in order that he may be claimed as an exemption. An example is where a friend comes to live with the taxpayer in his home. Temporary absences of the dependent from the taxpayer's home for reasons such as vacation, school, or sickness will not disqualify him as an exemption if the other tests are met.

A dependent, related in any one of the following ways, is not required to be a member of the taxpayer's household or to live with the taxpayer: (1) a son or daughter of the taxpayer, or a descendant of either; (2) a stepson or stepdaughter of the taxpayer; (3) a brother, sister, stepbrother, or stepsister of the taxpayer; (4) the father or mother of the taxpayer, or an ancestor of either; (5) a stepfather or stepmother of the taxpayer; (6) a son or daughter of a brother or sister of the taxpayer; (7) a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer. Ordinarily, an exemption for a cousin will not be allowed unless the cousin lives with the taxpayer as a member of his household. However, if for the taxable year the cousin receives

institutional care required as a result of a physical or mental disability, he may be claimed as a dependent if he meets all the other tests and was a member of the taxpayer's household before receiving the institutional care.

TEST 4 — CITIZENSHIP OR RESIDENCE

The dependent must be a citizen or a resident of the United States, or a resident of Canada, Mexico, the Canal Zone, or the Republic of Panama.

TEST 5 — JOINT RETURN

The dependent may not file a joint return with another person. To illustrate, suppose the taxpayer supported his daughter for the entire taxable year while her husband was in the armed forces. If the daughter and her husband prepare and file a joint return, the taxpayer may not claim his daughter as a dependent, even though all the other tests are met. Further, if the husband files a separate return and claims an exemption for the taxpayer's daughter, her father may not claim her as a dependent.

Dependent's Return: The dependent may claim the \$600 personal exemption on his own return, even though he has been claimed as a dependent. To illustrate, a medical student earned \$850 during the year. Since he had gross income of more than \$600, he must file a return in which he may claim a deduction of \$600. If his father furnished more than one-half of his support for the year and the other tests are met, his father is also allowed an exemption of \$600 for him as a dependent.

(To be continued)

MARICOPA COUNTY MEDICAL SOCIETY LIBRARY

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MEDICAL JOURNAL HOLDINGS AS OF JULY 1, 1958

A listing of the medical literature available in the various libraries of the state will be published at intervals.

American Heart Journal

Vol. 1 (1926) to date

American Journal of Cardiology

Vol. 15 (1931) to Vol. 40 (1940)

American Journal of Clinical Nutrition

Vol. 1 (1952) to date

American Journal of Clinical Pathology

Vol. 1 (1931) to date

American Journal of Digestive Diseases

Vol. 1 (1934) to date

American Journal of the Diseases of Children

Vol. 1 (1911) to date

American Journal of Gastroenterology

Vol. 21 (1954) to date

American Journal of the Medical Sciences

Vol. 1 (1821) to Vol. 61 incomplete

Vol. 61 (1871) to date

American Journal of Medical Technology

Vol. 15 (1949) to Vol. 23 (1957)

American Journal of Medicine

Vol. 1 (1946) to date

American Journal of Obstetrics and Gynecology

Vol. 1 (1921) to date

- American Journal of Ophthalmology
Vol. 1 (1918) to date
- American Journal of Pathology
Vol. 1 (1925) to date
- American Journal of Physiology
Vol. 145 (1945) to date
- American Journal of Proctology
Vol. 1 (1950) to date
- American Journal of Psychiatry
Vol. 26-28 (1869-1872) American Journal
of Insanity
Vol. 5 (1926) to date
- American Journal of Public Health
Vol. 1 (1911) to date
- American Journal of Roentgenology, Radium
Therapy, and Nuclear Medicine
Vol. 1 (1913) to date
- American Journal of Surgery
Vol. 1 (1926) to date
- American Journal of Syphilis, Gonorrhea and
Venereal Diseases
Vol. 1 (1917) to Vol. 40 (1940)
Publisher ceased publication
- American Journal of Tropical Medicine
and Hygiene
Vol. 15 (1935) to date
- American Practitioner
Vol. 1 (1947) to date
- American Review of Tuberculosis & Pulmonary
Diseases
Vol. 1 (1917) to date
- American Surgeon
Vol. 18 (1952) to Vol. 22
- Anesthesia & Analgesia
(Current Researches In—)
Vol. 1 (1922) to date
- Anesthesiology
Vol. 1 (1940) to date
- Angiology
Vol. 1 (1950) to date
- Annals of Allergy
Vol. 5 (1947) to date
- Annals of Clinical Medicine
Vol. 1 (1923) to Vol. 5
- Annals of Internal Medicine
Vol. 1 (1928) to date
- Annals of Otology, Rhinology & Laryngology
Vol. 29 (1920) to date
- Annals New York Academy of Science
Incomplete
- Annals of Rheumatic Diseases
Vol. 6 (1949) to date
- Annals of Surgery
Vol. 9 (1889) to date
- Archives of Dermatology & Syphilology
Vol. 7 (1923) to date
- Archives of Industrial Health
Vol. 1 (1950) to date
- Archives of Internal Medicine
Vol. 3 (1909) to date
- Archives of Neurology & Psychiatry
Vol. 1 (1919) to date
- Archives of Ophthalmology
Vol. 43 (1914) to Vol. 57 incomplete
- Vol. 1 (1929) to date
- Archives of Otolaryngology
Vol. 1 (1925) to date
- Archives of Pathology
Vol. 1 (1926) to date
- Archives of Physical Therapy
- Archives of Physical Medicine
Vol. 7 (1926) to date
- Archives of Surgery
Vol. 1 (1920) to date
- Arizona Pharmacist
1956 to 1957
- Bacteriological Reviews
Vol. 1 (1937) to date
- Balyeat Hay Fever & Asthma
Clinic Proceedings
Incomplete
Ceased publication
- Biophysics
Vol. 1 (1956) to Vol. 2 (1957)
- Brain: A Journal of Neurology
Vol. 60 (1937) to date
- British Journal of Anesthesia
Vol. 30 (1958)
- British Journal of Dermatology
Vol. 58 (1946) to date
- British Journal of Ophthalmology
Vol. 1 (1917) to date
- British Journal of Radiology
Vols. 21-23 (1925-1927)
Vol. 1 (1928) to date
- British Journal of Surgery
Vol. 31 (1944) to date
- British Medical Journal
Vol. 1 (1937) to date
- Bulletin of the American College of Surgeons
Vol. 35 (1950) to date
- Bulletin of History of Medicine
Vol. 28 (1954) to date
- Bulletin of the Johns Hopkins Hospital
Vol. 10 (1899) to date

- Bulletin of the Medical Library Association
Vol. 42 (1954) to date
- Bulletin of the Menninger Clinic
Vols. 11-19 (1947-1955)
- Bulletin of the New York Academy of Medicine
Vol. 4 (1928) to date
- Bulletin on Rheumatic Diseases
1951 to 1956 incomplete
- Canadian Medical Association Journal
Vol. 18 (1928) to date
- Canadian Services Medical Journal
Vol. 11 (1955) to Vol. 13
- Cancer
Vol. 1 (1948) to date
- Chemical Abstracts
Vols. 32, 34 (1938-1940) incomplete
Vols. 43-45 (1949-1951) incomplete
- Circulation
Vol. 1 (1950) to date
- Cleveland Clinic Quarterly
Vol. 1 (1934) to date
- Clinical Medicine
Vol. 3 (1956) to date
- Diabetes
Vol. 3 (1954) to date
- Diseases of the Chest
Vol. 1 (1935) to date
- Diseases of the Nervous System
Vol. 9 (1948) to date
- Electroencephalography & Clinical Neurophysiology
Vol. 5 (1953) to date
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Vol. 1 (1917) to date
- Federation Proceedings
Vol. 8 (1949) to Vol. 16
- Gastroenterology
Vol. 1 (1943) to date
- General Practice
Vol. 1 (1950) to date
- German Medical Monthly
Vol. 1 (1956) to date
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Vol. 1 (1946) to date
- Guy's Hospital Reports
Vol. 95 (1946) to date
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Vol. 75 (1953) to Vol. 81
- Industrial Medicine & Surgery
Vol. 1 (1932) to Vol. 26 (1957)
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Vol. 4 (1956) to Vol. 5
- International Abstracts of Surgery
Vol. 18 (1914) to Vol. 104 (1957)
- International Record of Medicine & General Practice Clinics
Vol. 16 (1951) to Vol. 170 (1957)
- Journal of Allergy
Vol. 1 (1929) to date
- Journal of the American Dental Association
Vol. 16 (1929) to date
- Journal of American Dietetic Association
Vol. 23 (1947) to Vol. 32
- Journal of American Geriatrics Society
Vol. 4 (1956) to date
- Journal of the American Medical Ass'n.
Vol. 41 (1903) to date
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Vol. 1 (1946) to date
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Vol. 32 (1948)
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Vol. 19 (1948) to Vol. 27
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Vol. 8 (1923) to date
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Vol. 71 (1926-1927)
Vol. 167 (1947) to Vol. 224 (1957)
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Vol. 6 (1924) to date
- Journal of Chronic Diseases
Vol. 1 (1958) to date
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Vol. 6 (1946) to date
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Vol. 1-11 (1924-1932)
Vol. 12-20 incomplete
Vol. 25 (1946) to date
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Vol. 1 (1946) to date
- Journal of Infectious Diseases
Vol. 24 (1919) to date
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Vol. 1 (1938) to date
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Vol. 1 (1938) to date
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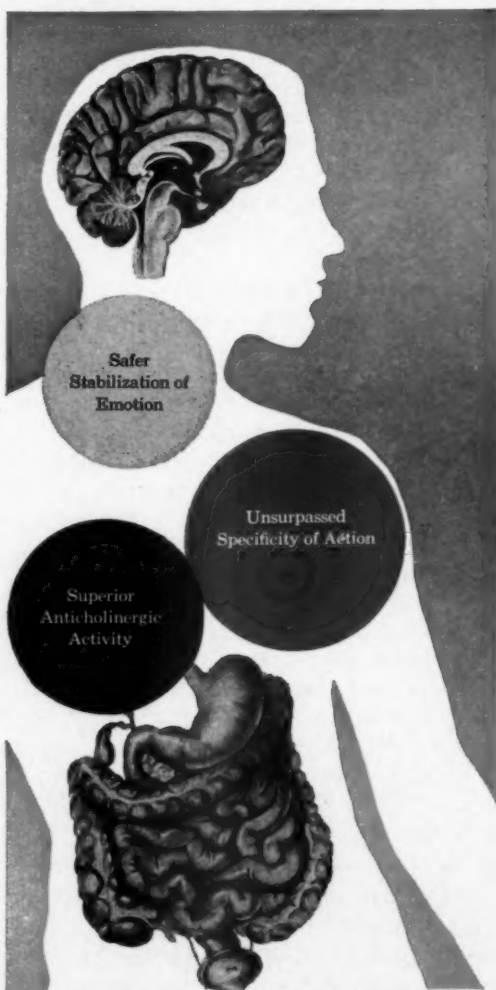
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Vol. 125 (1957) to date
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Vol. 10 (1951) to date
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Vol. 95 (1949) to date
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Vol. 68 (1941) to date
West Virginia Medical Journal
Vol. 26 (1930) to date
Wisconsin Medical Journal
Vol. 22 (1923) to date

ARIZONA POISONING CONTROL INFORMATION CENTER

*Progress Report From The Arizona Poisoning
Control Information Center At The University
Of Arizona College of Pharmacy*

TOXICITY STUDIES OF ARIZONA ORNAMENTAL PLANTS

AS STATED in the June 1, 1958 report, the Pharmacology Division of the University of Arizona College of Pharmacy in co-operation with the Arizona Poisoning Control Information Center has been carrying out toxicological studies with ornamental plants growing around homes in Arizona. This report will consider the *Pyracantha* shrub.

Pyracantha coccinea, Fam. *Rosaceae*: The ingestion of the bright red, berry-like fruit of the *Pyracantha* shrub has resulted in numerous inquiries at the Arizona Poisoning Control Information Center. It is estimated that during the 1957-58 fruit-bearing season of this shrub (November to March) an average of eight inquiries per week seeking information as to the potential toxicity of the *Pyracantha* berries were received from parents at the information center. The major portion of the incidents involved small children who obtained the fruit directly from the shrub.

Sub-acute toxicity studies were carried out by the pharmacology division with four species of animals, namely — three dogs, two rabbits, six white rats, and six guinea pigs. These animals were fed *Pyracantha* berries *ad libitum* for a period of 10 days. It was found that all consumed the berries readily with no need for forced feedings. For example, each dog ingested at least 300 Gms. of the berries each day. Frequently, a dog

would eat this quantity within one hour. The average daily diet of the berries for a white rat was 75 Gms. (One adult handful of berries weighs approximately 20 Gms.) A total of 13.7 Kg. (30 pounds) of *Pyracantha* berries were fed to these animals during the test period. The result of these tests revealed that no animal displayed ill effects from the ingestion of the large amounts of the berries.

From these experimental animal studies, it appears that *Pyracantha* berries are not harmful, especially in the relatively small amounts which might be consumed by children. However, the toxic potential of garden sprays used to combat red spiders on *Pyracantha* shrubs must not be overlooked when parents are given toxicity information concerning the fruit of this shrub. Lindane, Malathion and DDT are common constituents of these insecticide sprays. If a child should ingest the berries from a *Pyracantha* shrub that has been recently sprayed, treatment should be directed to the insecticide with less concern over the *Pyracantha* berries.

Bemegride Available as a Barbiturate Antagonist

Bemegride (beta-ethyl-beta-methylglutarimide) is now commercially available under the trade-name Megimide from Abbott Laboratories. The drug is a central stimulant and has been found useful for counteracting the central nervous system depression associated with barbiturate intoxication. It has been demonstrated to have an analeptic action similar to that of picro-

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toxin and Metrazol. However, Megimide is said to have a wider margin of safety, since it produces its effects at a dosage appreciably below that which results in convulsions. This antidote is usually administered IV in intermittent doses of 50 mg. every three to five minutes until the return of muscle tone, and pharyngeal and laryngeal reflexes.

Megimide is supplied in sterile 10 cc. vials, each containing 50 mg. dissolved in 10 cc. of isotonic saline. It is recommended that each of the 18 Arizona Hospital Poisoning Control Treatment Centers stock this antidote.

Statistics of 70 Poisoning Cases in Arizona Reported Since the June 1 1958, Progress Report

AGE:	Per Cent	Number
Under 5	61.4	(43)
6 to 15	2.9	(2)
16 to 30	20.0	(14)
31 to 45	8.6	(6)
Over 45	7.1	(5)
NATURE OF INCIDENT:		
Accidental	80.0	(56)
Intentional	20.0	(14)
OUTCOME:		
Recovery	100.0	(70)
Fatal	0.0	(0)
TIME OF DAY:		
Between 6 a.m. & noon	28.6	(20)
noon & 6 p.m.	25.7	(18)
6 p.m. & midnight	34.3	(24)
midnight & 6 a.m.	1.4	(1)
Not reported	10.0	(7)
CAUSATIVE AGENTS:		
Aspirin preparations	20.0	(14)
Sedatives (barbiturates & glutethimide-Doriden)	14.3	(10)
Solvents (gasoline, kerosene, turpentine, carbon tetrachloride)	24.3	(17)
Insecticides (chlor-dane, malathion, DDT, Real Kill Fly Spray)	10.0	(7)
Household bleaches, detergents (Chlorox, Spic and Span)	5.7	(4)
Food poisoning	5.7	(4)
Ornamental plant (oleander)	1.4	(1)
Miscellaneous (pine oil, brake fluid, Achromycin capsules, iodine, Dilantin capsules, Red Cross toothache drops, etc.)	18.6	(13)

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(To be continued)

AMERICAN COLLEGE OF CHEST PHYSICIANS

THE 24TH annual meeting of the American College of Chest Physicians was held at the Fairmont Hotel, San Francisco, June 18-22, 1958. Over 1,400 physicians and guests attended the meeting.

The following resolution was passed by the executive council June 21:

"In view of the vital interest in improving public health and welfare, and in the eradication of diseases of the chest in particular, our position regarding the use of BCG (bacillus Calmette-Guerin) against tuberculosis in the United States should be made known. At the present time, there is insufficient evidence that significant protection is afforded by its use. The council fully endorses the anti-tuberculosis control program of the U. S. Public Health Service, which includes research in BCG, and urges the continued support of their program."

Fellowship certificates were presented to 160 physicians at the convention held on Saturday, June 21.

Dr. J. Winthrop Peabody, Washington, D.C., professor emeritus, diseases of the respiratory system, Georgetown University School of Medicine, was awarded the 1958 college medal for his meritorious achievements in the specialty of diseases of the chest, particularly in the field of postgraduate medical education. Dr. Peabody has served as chairman of the council on postgraduate medical education of the college since its inception in 1945.

The following officers of the American College of Chest Physicians were elected for the year 1958-1959:

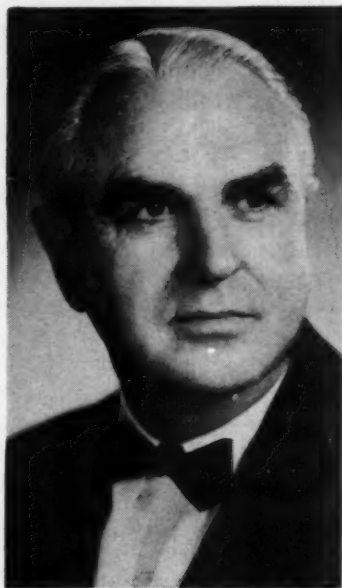
President, Donald R. McKay, Buffalo, N. Y.; President-elect, Seymour M. Farber, San Francisco, Calif.; First vice president, M. Jay Flipse, Miami, Fla.; Second vice president, Hollis E. Johnson, Nashville, Tenn.; Treasurer, Charles K. Petter, Waukegan, Ill.; Assistant treasurer, Albert H. Andrews, Chicago, Ill.; Chairman, board of regents, John F. Briggs, St. Paul, Minn.; and Historian, Carl C. Aven, Atlanta, Ga.

The College just passed its 6,000 membership mark this year.

CERTIFICATES OF FELLOWSHIP

The following physicians from Arizona were awarded Certificates of Fellowship in the American College of Chest Physicians:

Andre J. Bruwer, M.D., Tucson; John L. Cogland, M.D., Phoenix; Frederick W. Coleman Jr., M.D., Phoenix; Daniel H. Goodman, M.D., Phoenix; James T. Harold, M.D., Phoenix; Mayer Hyman, M.D., Tucson; Donald W. Merkle, M.D., Whipple; George Spurbeck, M.D., Phoenix; and Hans F. Stein, M.D., Tucson.



Howell S. Randolph, M.D.

NEW CHAIRMAN, AMERICAN COLLEGE OF CHEST PHYSICIANS

Dr. Howell S. Randolph is new board of governors chairman of the American College of Chest Physicians. A staff member of St. Joseph's, St. Luke's, Good Samaritan, and Maricopa County General hospitals, he was elected to the post at the organization's recent annual meeting in San Francisco.

HILL-BURTON GRANTS FOR ARIZONA

THE U.S. Department of Health, Education, and Welfare reports that as of June 30, the status of all Hill-Burton grants for the state of Arizona is:

Approved but not yet under construction: 23 projects at a total cost of \$15,177,287, including \$4,787,467 federal contribution, and designed to supply 914 additional beds.

Under construction: 11 projects at a total cost of \$5,211,247, including federal contribution of \$2,031,969 and designed to supply 262 beds.

Completed and in operation: Three projects at a total cost of \$3,438,815, including federal con-

tribution of \$844,880 and supplying 170 additional beds.

CANCER RESEARCH

A UNIVERSITY OF Pennsylvania scientist has found an explanation for the paradoxical behavior of various anti-cancer drugs and, on this basis, has proposed a new approach to the problem of the chemical treatment of cancer.

This was announced by the American Cancer Society which supports research by the scientist, Dr. L. V. Heilbrunn, professor of zoology. Associated with Dr. Heilbrunn are Dr. W. L. Wilson and T. R. Tosteson, E. Davidson and S. A. Ferguson.

Dr. Heilbrunn several years ago discovered that before cells divided, their protoplasm changed from a fluid to a semi-solid gel. Unless the protoplasm clotted — much as blood does — the cells could not divide.

This finding inspired a search by the Heilbrunn and other research groups for substances which might prevent the clotting of protoplasm and the division of cells. Such a substance, if it proved specific for cancer cells and did not injure normal cells, would meet the theoretical requirements for a cancer cure.

Recently the Heilbrunn group tested their findings against a paradox noted by other scientists. The paradox is that virtually every drug used effectively to treat cancer in animals and humans itself causes cancer. X-rays, too, have these contradictory qualities of causing and, in some cases, even curing cancer.

The Pennsylvania scientists found that the anti-cancer drugs in certain dosages prevented cells from dividing. The drugs did this by keeping the cell protoplasm in a fluid state. Other workers have found that cells treated with these drugs would increase greatly in size; but, unable to gel and divide, eventually they would die.

These findings explained what anti-cancer drugs probably did to cells. But they left still unsolved one of the major problems: How do these drugs do it — on what part of the cell do they act?

Answer and Key

The Pennsylvania group now have an answer. And they have found a key to the chemistry of the cancer-causing and cancer-curing phenomenon.

They have noted that when cells are about to

divide, calcium which is bound to other chemicals near the cell surface is set free. The freed calcium enters the cell interior and there causes the clotting which permits cell division.

Only in some instances, however, does the release of calcium permit cell division. Sometimes it blocks clotting and cell division. And on still other occasions, it peppers the cell interior with large cavities and kills the cells.

These diverse effects, it now appears, are due to the concentrations of the drugs used, whether or not they are dissolved (unless they are dissolved they may be inactive) and whether they produce an acid or alkaline environment within the cell.

Preliminary results indicate that in dilute concentrations the drugs prevent cell division, in moderate concentrations they promote cell division, and in very high strength they kill the cells.

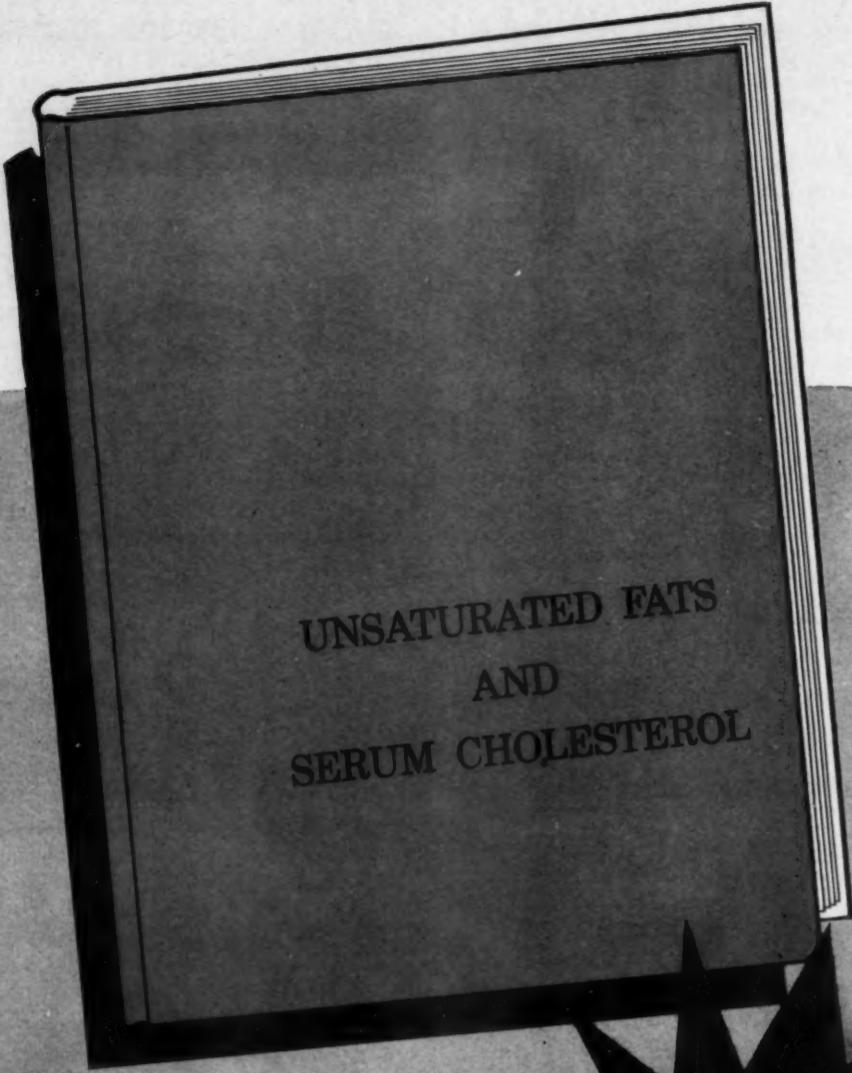
In these experiments, the Heilbrunn group used the eggs of sea urchins and certain worm eggs which are shed into sea water. The scientists believe that the process of cell division and protoplasm characteristics are the same throughout the animal kingdom. Because these cells divide with predictable frequency, they lend themselves to mathematically calculable experiments.

Among the anti-cancer drugs tested were two kinds of nitrogen mustard and urethane, and 6-mercaptopurine.

In all concentrations the drugs released calcium from the cell surface. Moderate amounts of the drug made the cell divide. The highest concentrations, however, produced bubble-like structures in the cell fluid and killed the cell. Small amounts kept the protoplasm fluid and blocked cell division.

Role of Urethane

This was the case with urethane, originally used as an anesthetic for experimental animals and later found both to benefit some cancer patients and also to cause cancer in animals. The Heilbrunn and other groups observed that urethane not only liquefied the outer membrane of the cell and released calcium, but it went into the cell's interior, where it prevented the freed calcium from causing protoplasmic clotting and cell division.



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monly recommended by authorities on nutrition—that from one-third to one-half of the total fat in-take should be of the unsaturated type when serum cholesterol control is a problem.

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The common anesthetic, ether, had a similar action — in dilute form it prevented cell division, and in high concentrations speeded cell division.

The experiments have led to a search for natural substances which block cells from dividing.

One of the kinds of cells which do not divide for many years is the female egg, or ovum. A girl baby is born with all the ova she ever will have — something in the ovary keeps these cells from dividing from birth until adult years when the ova are shed, one each month.

Dr. Heilbrunn found that ovaries contained a substance which stopped cells of many kinds from dividing. This substance he identified as protein-bound polysaccharides. Heparin, the anti-clotting agent used in blood conditions, is a polysaccharide, or complex of sugars.

In test tube experiments, polysaccharides extracted from ovaries have delayed or inhibited cell division. Moreover, ovarian extracts containing such polysaccharides have been rather effective in curing one type of cancer in mice, as has been shown by experiments on some thousands of animals. A report on this work is now in press in the *Journal of the National Cancer Institute*.

The Heilbrunn group feel that the principles established in this basic research may be used to advantage in man's search for effective anti-cancer drugs.

PHYSICAL chemists at the University of Cincinnati have produced a picture of the arrangement of the particles and the energy sources in a cancer-causing molecule and helped to open the way to a basic understanding of disease-producing chemistry.

The results of this research by Drs. H. H. Jaffé, Si-Jung Yeh and R. W. Gardner were reported by the American Cancer Society which supports the project. The picture produced definitely resolves an old controversy on the nature of atomic arrangements in a compound which can transform a normal, useful cell into one which becomes a predator on the body and brings death to the host.

The results are based on observations of the atomic groupings and electronic forces within and around a molecule of an azo dye called p-dimethylaminoazobenzene, formerly used as a

food coloring in butter, and now commonly fed to rats to induce liver cancer. The determinations of atomic arrangements permitted the scientists to make exquisite mathematical calculations of the enormous energies in various areas of the azo dye molecule. These calculations lay the groundwork for investigating the cancer-inducing reactions between azo dyes and cell chemicals.

The scientists used a spectrophotometer to identify the atoms and their configuration within the azo dye molecule.

Excerpts of informal remarks by Mr. Mefford R. Runyon at the regional meeting held in New York City, June 4 and 5, 1958:

CANCER of the rectum and colon will be the subject of the scientific session at the annual meeting next fall. And we are hoping that when the time is ripe, to launch an attack on this particular cancer somewhat along the line of the breast self-examination and the cytology programs. It seems this is a most effective way in which to attack the cancer problem — that is against cancer of a particular site, mobilizing professional and public education and service.

The society has concerned itself for many years in the subject of appropriations — financial support — for the National Cancer Institute, the cancer work of the United States Public Health Service. The society has taken the responsibility — I suppose you might say — to inform the congress — through appropriate hearings and through appearances and statements before proper committees — of the growing magnitude of the cancer problem in this country and of the necessity of an all-out attack on it, if we are to handle the thing with any degree of adequacy. This educational process has resulted in the congress's growing appreciation of this disease problem. It is making the necessary appropriations and other arrangements for attacking it in an increasingly aggressive manner. Last year the appropriations were about \$56 million for the National Cancer Institute. This year the house already passed \$59 million. Hearings before the senate appropriations sub-committee were held on May 16, and I believe the mark-up has been made. This is usually somewhat higher than a house figure. (The senate on June 20 passed a figure of \$81 million.) Then the two

groups go into conference and it is our expectation that perhaps this year they will come up with at least \$64 or \$65 million for the work of the National Cancer Institute.

Medical Facilities Needed

There is another area of federal appropriations in which we have played an effective part. That is in the field of construction of much needed medical research facilities. Three years ago, legislation was passed authorizing appropriation of \$30 million a year on a matching basis, for this purpose — not only cancer research facilities, but medical research facilities of all sorts — \$90 million spread over a three year period, and the people who got these grants were required to put up at least another \$90 million. That proved to be an exceptionally effective piece of pump priming. All the money authorized was applied for several times over and it is expected that the authorization will be extended until the backlog of required medical research facilities is taken care of.

Last year there was also a proposal for appropriations for the construction of medical teaching facilities in addition to research facilities. The medical schools need financial help to expand their facilities to take care of the greater number of subjects which a doctor has to learn now-a-days, as well as the greater number of students. The bill was not passed last year, but this year it is being tackled again and I think the outlook is fairly good for some sort of legislation along this line, probably in the current congress. This is a matter in which the cancer society is not taking a lead, but we are working closely with the Association of American Medical Colleges and with others who are interested.

Smoking

In the field of cigaret smoking and its influence as a health hazard or as a cause of death, there are developments which I would like to touch on very briefly. The matter of how to approach high school students before their habits are crystalized is one which we are looking into carefully. In the current year, we hope through some field tests to find out what is the best way of reaching them to make certain that they decide for themselves about smoking with full knowledge before the cigaret habit becomes fixed. There have been some pamphlets and some movies produced — these movies are not ours — but we think the proper psychological approach to the high school students — what motivates them — is something we should study carefully before we act.

The next interesting development in this field of smoking and lung cancer will be the statistical report from the U. S. Public Health Service which will be given at the Seventh International Cancer Congress in London. They have been conducting a study on the holders of National Service life insurance somewhat along the line of the study we made on 200,000 men — excepting here they have a much larger group, a group that goes back to World War I as well as World War II. They have tabulated their smoking habits, relating them to subsequent death rates, by causes, and so on. Rumors about this report caused the stock market and tobacco stocks to react very sharply. I do not know where the rumors came from, but the New York Times ran it down and found from Dr. Harold Dorn he would give no information at this time, but stated at the proper time the full report would be disclosed.

ERYTHROBLASTOSIS FETALIS

by Fred H. Allen, Jr., M.D. and Louis K. Diamond, M.D. 143 pages. Illustrated. (1058) Little, Brown. \$4.

Here is a clear, concise presentation of the current status of erythroblastosis and the blood factors by which it is caused. The potentially responsible blood groups are listed, the pathogenesis is reviewed and considerable attention is directed to clinical diagnosis. Indications and techniques of exchange transfusion are well detailed. The authors are from Harvard Medical School.

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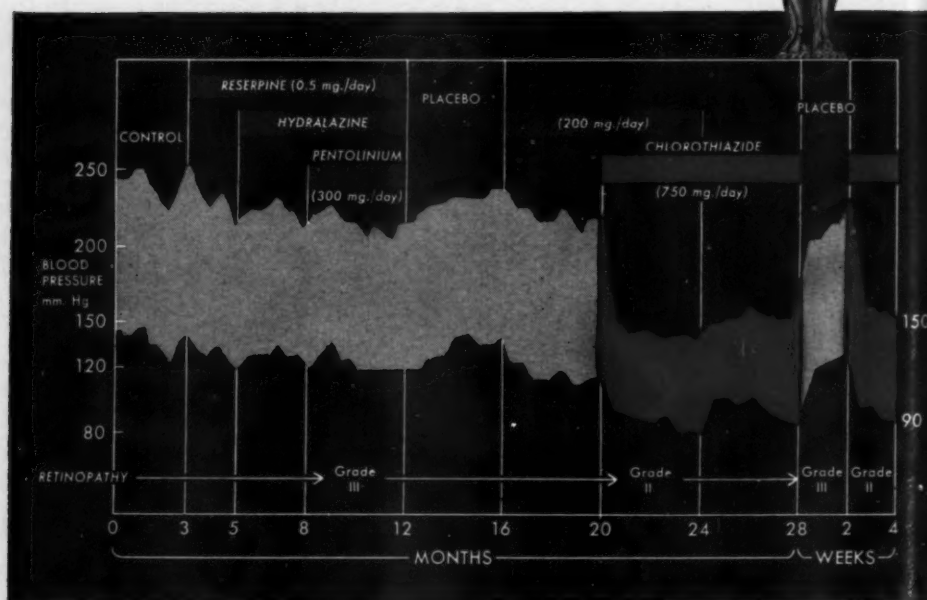
after investigator reports the

Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide." "... it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). ..."

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension,"

Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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QUIZ — HISTORY OF MEDICINE* (Cont.)

These questions were used by John Green, M.D., in his course for premedical students at the Arizona State College at Tempe. We suggest that the reader take this quiz. The answers will be

found on another page. Forty per cent correct answers can be considered fair, 70 per cent good, and 90 per cent excellent.

By John Green, M.D.

1. The sixth king of the 1st dynasty of Babylon, Hammurabi, in 1900 BC influenced the practice of surgery. How did he accomplish this?

2. Who was the special god of medicine of Egypt? His cult antedated that of Aesculapius by many centuries. He lived about 3000 BC, was a magician-physician, priest, sage, scribe, astronomer, grand vizier, architect, etc.

3. Why did the physicians of India, China, and Arabia know so little about anatomy?

4. What was the major basis for the knowledge of anatomy possessed by Hippocrates, Galen and their contemporaries?

Was Herophilis, the noted physician of Alexandria of the third century BC any exception from the standpoint of his anatomical experience and knowledge?

Why?

5. Julius Caesar profoundly affected the medical profession for the better. In what way did he do this?

6. Albucasis, the greatest surgeon of Islam, cauterized for many medical conditions during the 10th century, and this led to future excesses in the use of cautery. What was the rationale for the use of cautery in disease?

7. Gilles de Corbeil was one of the most renowned Salernitans of his time. His medical works on what subject were standard for the next 500 years? This subject loomed large in all diagnoses from about 1160 to 1660 AD, and was almost always included in pictures of physicians of the period.

8. The Medical Renaissance has been dated to the discovery of an important manuscript in 1443 and its publication in 1478. Who wrote this manuscript?

9. Paris, in the times of Ambroise Pare — the towering surgical figure of the 16th century, had its medical profession separated into three classes. What were they?

10. William Harvey will always be remembered for providing the discovery which enabled physiology to advance and clinical medicine to become intelligible. What was this discovery, published in 1628 AD?

11. Discuss what you know about Edward Jenner (1749-1823) and his contribution to medicine.

12. Discuss what you know about William Beaumont (1785-1853) and his great contribution to medicine.

13. With what two names do you associate the discovery of the contagiousness of childbed fever (puerperal sepsis)?

14. The medical achievements of the 19th Century were impressive. Name six major achievements of this period.

Answers on page 686.

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*Final Exam, History of Medicine, Arizona State College at Tempe, Pre-medical Course.

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ANSWERS TO
HISTORY OF MEDICINE QUIZ

1. Codified the responsibility of the physician to his patients.
2. Imhotep.
3. Dissention was not permitted by the Hindu, Buddhist or Moslem religions.
4. Animals, except that human osteology was fairly well understood. Herophilus dissected humans with considerable success.
5. In 46 BC, Julius Caesar granted Roman citizenship to physicians, the majority of whom were Creek slaves.
6. The theory of counter-irritation. It was used in migraine, epilepsy, cramps, etc., wherever the patient complained of pain or discomfort.
7. He wrote on the urine.
8. Celsus.
9. Physicians, surgeons, barber-surgeons.
10. The circulation of the blood.
11. The story of vaccination for smallpox.
12. The story of the study of gastric physiology made possible by the gastric fistula of Alexis St. Martin following a gunshot wound of the abdomen.
13. Oliver Wendall Holmes Sr. and Ignaz Semmelweis.
14. (1) The discovery of auscultation by Laennec, 1816, (2) The introduction of x-ray by Roentgen, 1895, (3) The cellular theory of Virchow, shedding light on the nature of disease, and destroying the erroneous humoral doctrine of the previous 2,000 years, (4) The rise of bacteriology, Pasteur, Koch, etc., (5) The discovery of ether anesthesia, and (6) The development of antiseptic and aseptic surgery.

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NATIONAL FUND FOR MEDICAL EDUCATION

TO HELP support the search for new medical knowledge and to increase the number of trained medical researchers, the National Fund for Medical Education has established a medical research program through which contributions from united funds, community chests, voluntary health agencies and other organizations will be channelled into basic research, Fund President S. Sloan Colt announced.

The United Community Funds and Councils of America, whose local affiliates have expressed a desire to help support broad fundamental programs of basic medical research on a national level, have agreed to support this new research program.

It is our hope, Colt said, that the voluntary health agencies which have so generously supported the categorical research into specific diseases will also support this new program.

This expansion of the National Fund's pro-


gram, it was stated, will in no way affect its campaign among corporations to obtain support for the teaching budgets of the accredited medical schools in the United States.

Colt, who recently retired as chairman of the Bankers Trust Company of New York City, declared that the contributions sought for the new program are over and above local contributions for research in specific diseases: cancer, heart, polio, cerebral palsy and others. He added:

"By supplementing categorical research into the specific diseases, this research program of the fund will help to broaden overall research activities, and will be an important stimulus to the advancement of the medical sciences."

The new program, it is expected, will not only help advance the search for basic medical knowledge and encourage the training of research personnel, but will also help the nation's medical schools and other research institutions maintain a proper balance between basic and "project, or applied, research."

The greatest need in research today, Colt



In a recent 140-patient study¹ DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.

1. Thomas, J. W.: Ann. Allergy 16:128, 1958



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continued, is for the support of basic research and the training of research personnel. The bulk of research money available at present is for project research. Creative research — the exploratory probing and groping in the unknown — too often must be financed out of meager general funds.

In 1952, the fund president pointed out, a committee of medical educators published the results of a five year study of medical education in which they declared that, in the financing of medical research, the most urgent need is for institutional — not project — research.

Because a major portion of medical research is carried on in the medical schools, whose faculties both teach and conduct research, Colt said he was confident that the new program would help many schools to further improve the quality of undergraduate medical education. Fund grants, at present principally supported by corporation contributions, are unrestricted but are used primarily for support of teaching budgets of the medical schools. Today, pure research and applied research supplement each other and both are important elements in the educational function of the schools.

Details of the new program were worked out by a committee composed of business men and

educators, which included:

Dr. Vernon W. Lippard, Dean, Yale University School of Medicine, chairman; S. Sloan Colt, president, National Fund for Medical Education; Dr. James M. Faulkner, medical director, Massachusetts Institute of Technology; Dr. Joseph C. Hinsey, director, New York Hospital — Cornell Medical Center; Mr. T. V. Houser, former chairman, Sears Roebuck & Co.; Dr. Carlyle Jacobsen, president, State University of N. Y. College of Medicine at Syracuse; Devereux C. Josephs, chairman, New York Life Insurance Company; Dr. John McK. Mitchell, Dean, University of Pennsylvania School of Medicine; Eustace Seligman, partner, Sullivan & Cromwell; Juan T. Trippe, president, Pan American World Airways; and Dr. W. Clarke Wescoe, Dean, University of Kansas School of Medicine.

The National Fund for Medical Education was formed in 1949 under the leadership of President Dwight D. Eisenhower, then president of Columbia University; former President Hoover, who is honorary chairman of the fund's board of trustees; leading educators, university presidents and prominent business leaders.

The fund recently awarded \$3,178,825 to the medical schools, bringing to \$15,843,766 the total awarded since its first grants were made in 1949.

STATEMENT OF PRINCIPLES CONCERNING PARAMEDICAL WORKERS IN RELATION TO MEDICINE

By National Medical Foundation
for Eye Cancer*

I

MEDICINE must re-establish its primacy, its over-all responsibility and authority, in the realm of medical care.

II

Medicine should undertake to define the conditions under which any paramedical groups may or should be licensed. (Does the public interest require their licensure, or would licensure only lead to independent functioning which is not in the public interest?)

III

In the interest of a better co-ordinated professional service, medicine should determine and define the need for each paramedical group, its

functions, its educational standards, and the manner in which its members (whether licensed or unlicensed) are to be recognized and supervised.

IV

Medicine should assert the principle that every physician has the legal right to do anything for the patient that his medical care requires, and that he further has the right to delegate to any paramedical worker any technical procedure.

V

Medicine should further assert the principle that whatever privileges may at any time be granted to limited practitioners or paramedical workers, whether by law or otherwise, such grant in no way circumscribes the physician's authority in that field, and in no way restricts the practice of medicine by the physician.

VI

The medical profession as a whole should

*Adopted as an official statement of the foundation by its board of trustees, May 27, 1953. Additional copies available from the foundation at 250 W. 37th St., New York 18, N. Y.

recognize the basic fact that whenever any paramedical group succeeds in establishing independent status in any area of professional medical practice, or in circumscribing or compromis-

ing the authority of the physician in any area of professional medical practice, the threat or the damage extends to all of medicine and should be of concern to the entire medical profession.

THE ARIZONA MEDICAL ASSOCIATION, INC.

826 Security Building

Phoenix, Ariz.

LOCATION INQUIRIES

ACUFF, WILLIAM J., M.D., 606 W. Sixth St., Caruthersville, Mo.; GP; graduated from the University of Tennessee School of Medicine, 1956; interned at U.T. Memorial Hospital, Knoxville, Tenn. Has since been engaged in general practice and surgery. Age 28. Desires to locate in the Phoenix or Tucson area. Prefers industrial-general type practice. Is available now.

BRILL, JAMES R., M.D., 23 Church St., East Randolph, N. Y.; GP; graduated from University of Buffalo, 1943, and interned at Jefferson Medical College Hospital. Is exempt from military service and is 41 years of age. Desires assistant or group practice and is available immediately.

HILLMAN, FREDERICK JOSEPH, M.D., 428 Medical & Dental Bldg., Everett, Wash.; GS; age 36, a graduate of the Washington University School of Medicine and interned at Madigan Army Hospital, Tacoma, Wash. Has completed his military obligations. Has had solo surgical practice in Washington and now wishes to relocate with clinic or associate with surgical practice. Will be available as soon as present office can be closed.

SHARP, WILLIAM C., JR., M.D., 109 Hale Road, Knoxville, Tenn.; Path; graduated 1946 from University of Tennessee School of Medicine and interned at Knoxville General Hospital. Has served a residency in pathology at the Armed Forces Institute of Pathology. Has had 10 years active duty in the armed forces. Will practice specialty of pathology and will be available Sept. 1, 1958.



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SUGIYAMA, WILLIAM M., M.D., U. S. Army Medical Center, Camp Zama, APO 343, San Francisco, Calif. Is 41 years old, oriental, and citizen by birth. Is a graduate of Western Reserve University, 1949, and interned at the Cleveland City Hospital. Desires group practice and wishes to do general surgery. Available Aug. 30, 1958.

McSWEENEY, AUSTIN J., M.D., 1217 Martin

Road, Janesville, Wisc., 1; a graduate of Stritch Medical School, Chicago, 1949, and interned at Buffalo City Hospital. Is licensed in the states of Illinois, Minnesota, and Wisconsin and certified by the American Board of Internal Medicine. Desires clinic or associate to practice specialty of internal medicine and is available now.

LOCATION OPPORTUNITIES

ASHFORK — Pop. 700. North centrally located. Railroad center. Contact the Women's Club, Ashfork, Ariz.

BENSON — Excellent opportunity for GP. This St. David-Benson trade area has about 5,000 population with only one doctor available. A small sleep-in hospital can be set up very easily. Hospital 25 miles away. Chamber of commerce will furnish telephone answering service, nine to five. Contact Bernard Fisher, D.D.S., Medical Committee of the Chamber of Commerce, Benson, Ariz., or James M. Hesser, M.D., Sixth and Huachuca, Benson, Ariz.

CAMP VERDE — Located in the heart of a large farming and ranching area on the Verde River. Approximately 100 miles north of Phoenix. Badly in need of medical doctor. Contact Ivy N. Moser, R.N., Camp Verde, Ariz.

FLAGSTAFF — Pop. 17,500. Largest city in the north central Arizona trading area. Excellent opportunity for an EENT doctor. Contact K. O. Hanson, M.D., secretary, Coconino County Coconino County Medical Society, 5 N. Leroux, Flagstaff, Ariz.

GILA BEND — Pop. 2,500. 80 miles west of Phoenix. Nearest town to the Painted Rock Dam Project. Good opportunity for general practitioner. Cattle, cotton, and general farming. Office and equipment available. \$150 monthly income from board of supervisors. Contact Mrs. J. F. Allison, Box 485, Gila Bend, Ariz.

HAYDEN — Pop. 3,000 to 4,000. Industrial practice. Approximately 200 employees and dependents. Only part-time required. Coverage: Metropolitan Surgical Plan. Physician may engage in private practice also. Small company-owned clinical building (new) available for use, with X-ray equipment, diathermy equipment, etc. Full-time nurse available to assist; clerical work to be handled by company. Company housing facilities available for physician — small

rental. Beginning Sept. 1, 1958. Contact: American Smelting & Refining Company, Mr. Ben Roberts, Dept. Mgr., P. O. Box 1111, El Paso, Texas.

HOLBROOK — Population above 7,000. Located in the heart of the northeastern pine country of Arizona on U. S. Rt. 66. Need services of GP. For full details, contact Donald F. DeMarse, M.D., Box 397, Holbrook, Ariz.

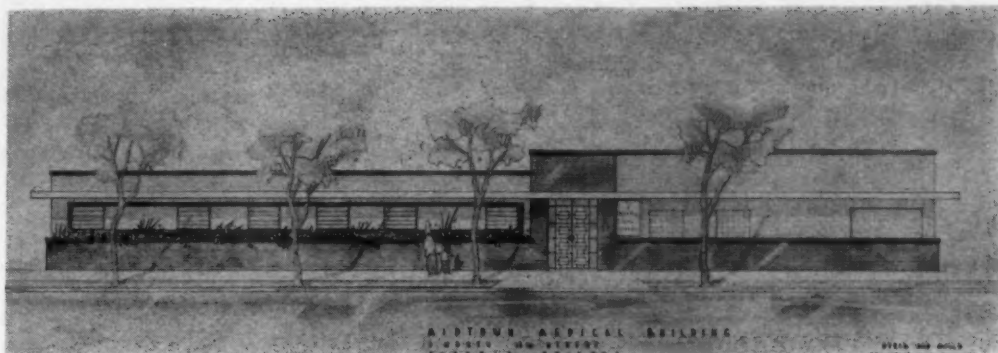
MIAMI — Opportunity for GP. Industrial hospital staffed by approximately seven doctors, who care for personnel and families of those who work for the three principal mining companies. Community served by many mining and ranching interests. Contact Robert V. Horan, M.D., Miami-Inspiration Hospital, Miami, Ariz.

MORENCI — Mining community near New Mexico-Arizona border. Pop. 10,000. Has vacancy at hospital for GP. Contact Carl H. Gans, M.D., Morenci Hospital, Morenci, Ariz.

ST. JOHNS — Seriously need a doctor of medicine, preferably a general practitioner, in this east-central Arizona community. Population is approximately 1,500 with several other small towns in the general area. About 20 miles from New Mexico in the beautiful rim country of Arizona. Contact Donald F. DeMarse, M.D., Box 397, Holbrook, Ariz.

TOLLESON — In need of GP. Serves a trading population of from 12,000 to 15,000. Ten miles west of Phoenix, with elementary and high schools, churches of all denominations. Complete office and equipment for GP is available on reasonable term lease or purchase. Contact Mr. Peter Falbo, president, chamber of commerce, 9112 West Van Buren St., Tolleson, Ariz.

TUCSON — The VA hospital is in urgent need of an orthopedic surgeon. They prefer someone who is board certified, but would take someone who has had special training as they have the local men in this field available for consultation service. State license is necessary (but not



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Two examining rooms — One consultation room

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necessarily an Arizona license). Contact S. Netzer, M.D., Director, Professional Service, VA Hospital, Tucson, Ariz.

**FOR INFORMATION ON OPPORTUNITIES
IN THE FIELD OF INDUSTRIAL
MEDICINE, CONTACT:**

Harold J. Mills, M.D., Phelps Dodge Hospital, Ajo, Ariz.

Carl H. Gans, M.D., Phelps Dodge Hospital, Morenci, Ariz.

Ira E. Harris, M.D., Miami-Inspiration Hos-

pital, Miami, Ariz.

Charles B. Huestis, M.D., Box 928, Hayden, Ariz.

Elvie B. Jolley, M.D., Copper Queen Hospital, Bisbee, Ariz.

H. W. Finke, M.D., Magma Copper Company Hospital, Superior, Ariz.

John Edmonds, M.D., Kennecott Copper Corporation Hospital, Ray, Ariz.

Francis M. Findlay, M.D., San Manuel Hospital, San Manuel, Ariz.

SOUTHWESTERN SURGICAL CONGRESS

ANNUAL AWARD COMPETITION

Eligibility

THE AWARD competition is open to M.D.s in active training in general surgery, or the surgical specialties, or who have been in private practice no more than three years beyond completion of resident, interne and post-graduate training. Eligibility is further restricted to those individuals who are within the geographic confines of the Southwestern Surgical Congress.

Subject Material

Subject material acceptable shall be either pure investigative or scientific research, or clinical research and investigation, which shall consist wholly or largely of the essayist's contributions, the work to be started while the doctor is in training and must be completed and reported within three years of completion of his training. The work shall not be merely medical and social service reporting for the convenience of a chief of staff, but is intended to encourage original study and investigation on the part of the essayist himself. The essayist should assume the major role in preparation of the material so

that in the event of publication, he himself shall be considered the senior author of such essay. The quality of the paper to receive an award consideration must be of sufficient merit to satisfy the essay award committee's evaluation, and only such papers as merit the committee's acceptance will be judged in the competition.

Presentation

The essayist(s) whose paper is selected to be read at the annual meeting during the scientific program, will be the invited guest of the Southwestern Surgical Congress during the annual meeting; this to include the essayist's wife if he is married, and includes lodging, meals and the social functions of the organization, but does not provide transportation to and from the meeting, which is the essayist's own responsibility.

The first award to be made at the next annual meeting of the Southwestern Surgical Congress, Denver, Colo. — March 30-31 — April 1-2, 1959. *Abstracts Due for Consideration by Dec. 15, 1958*

Interested persons please contact J. R. Schwartzman, M.D., 2415 E. Adams, Tucson, Ariz.

The total amount of the awards has been approved at \$600, to be distributed in the following manner: \$300 for first, \$200 for second, and \$100 for third prize in the award competition.

BURNS: Pathology and Therapeutic Applications
by Simon Sevitt, M.D. 364 pages. Illustrated. (1957) Butterworths. \$7.50.

The author, a pathologist, has collected his data and experience primarily from burns observed over a period of 10 years at the Birmingham Accident Hospital. Pathologic changes are interpreted in terms of clinical effects. Chapters take up the skin, infection, mortality, and body systems affected in the burned patient. Clinical and therapeutic lessons conclude most chapters. A thorough presentation takes a new slant, that of the pertinent pathology.

Stacey's Medical Books, San Francisco, California.

MANUAL OF PEDIATRIC PHYSICAL DIAGNOSIS
by Lewis Barnes. 195 pages. Illustrated. (1957). Year Book. \$4.

This booklet grew from expanded mimeographed notes for medical students, Pennsylvania, on the physical examination of children. In addition to listing and briefly discussing physical signs, an excellent introductory section on establishing rapport with the child is included. Techniques for restraint are also described. It is pocket size and the type is good.

Stacey's Medical Books, San Francisco, California.



running noses

and open stuffed noses orally

Relief in minutes...lasts for hours

In the common cold, nasal allergies, sinusitis, and postnasal drip, one timed-release Triaminic tablet brings welcome relief of symptoms *in minutes*. Running noses stop, clogged noses open—and *stay* open for 6 to 8 hours. The patient can breathe again.

With *topical* decongestants, "unfortunately, the period of decongestion is often followed by a phase of secondary reaction during which the congestion may be equal to, if not greater than, the original condition. . . ." The patient then must reapply the medication and the vicious cycle is repeated, resulting in local overtreatment, pathological changes in nasal mucosa, and frequently "nose drop addiction."

Triaminic does not cause secondary congestion, eliminates local overtreatment and consequent nasal pathology.

*Morrison, L. F.: Arch. Otolaryng. 59:48-53 (Jan.) 1954.

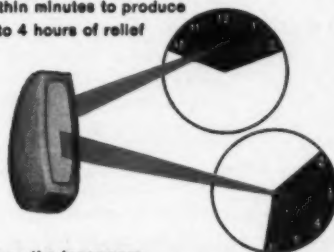
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Each timed-release tablet keeps the nasal passages clear for 6 to 8 hours—provides "around-the-clock" freedom from congestion on just three tablets a day

first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief



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Future Meetings

ARIZONA ACADEMY OF GENERAL PRACTICE CONVENTION:

Place: Valley Ho, Scottsdale, Ariz. *Date:* Oct. 2-4, 1958. *Registration Fee:* \$5.

In October, the Arizona Academy of General Practice is holding its annual state convention at the beautiful Valley Ho, in Scottsdale, Ariz. This is going to be an excellent program, and all physicians are cordially invited. The following is a tentative program:

Thursday, Oct. 2:

9 a.m. — Registration

Registration fee \$5. This fee will include the president's cocktail party and buffet supper, board of directors' meeting, meeting of the nominating committee, and exhibits.

2 p.m. — Call to order — President Walter Brazie, M.D.

2:30 p.m. — "Electrocardiography, Its Techniques and Clinical Applications" — Samuel J. Grauman, M.D., Tucson, Ariz.

3:30 p.m. — "Current Status of Sterility Investigations — Both Medical and Psychological" — Robert N. Rutherford, M.D., Seattle, Wash.

4:30 p.m. — Adjourn for afternoon

6:30 p.m. — President's reception, informal, cocktail party, buffet dinner.

Friday, Oct. 3:

9 a.m. — "Electroencephalography, Its Techniques and Clinical Application" — Richard D.

Walter, M.D., Los Angeles, Calif.

10 a.m. — "Lumps in Kids" — William Clatworthy, M.D., Columbus, Ohio.

11 a.m. — Recess.

11:30 a.m. — Annual business meeting.

2 p.m. — "Modern Amnesia and Analgesia Routines in Pregnancy" — Robert N. Rutherford, M.D., Seattle, Wash.

3 p.m. — "Recognition and Treatment of Some Common Ocular Problems" — James Calkins, M.D. and A. K. Hansen, M.D., Tucson, Ariz.

4 p.m. — "The Evaluation of Psychosomatic Complaints" — Frank J. Ayd Jr., M.D., Baltimore, Md.

5 p.m. — Adjourn.

Saturday, Oct. 4:

9 a.m. — "Stelazine Therapy for the Psychosomatic Patient" — Frank J. Ayd Jr., M.D., Baltimore, Md.

10 a.m. — "When to do What in Infant Surgery" — H. William Clatworthy Jr., M.D., Columbus, Ohio.

11 a.m. — "Electrocardiography, Audiocardiography, Its Clinical Applications and a Demonstration" — Samuel J. Grauman, M.D., Tucson, Ariz.

12 noon — Adjournment of the 1958 annual convention.

2 p.m. — Golf tournament

7 p.m. — Formal dinner dance and cocktail hour. Installation of new president. Award for golf tournament. Guest speaker — Mac F. Cahal, secretary, AAGP. Dancing.

PHYSICIAN'S VENEREAL DISEASE SEMINAR

TUCSON and Phoenix will be the setting for two physician's Venereal Disease Seminars to be held during the week of October 6th, according to Clarence G. Salsbury, M.D., Commissioner of Health. One of these seminars will be held on October 7th and 8th in Tucson; the other on October 9th and 10th in Phoenix.

According to Doctor Salsbury, these seminars will be a joint project of the Arizona State Department of Health, the Venereal Disease Branch of the U. S. Public Health Service, the Arizona Medical Association, and the medical societies of Maricopa and Pima counties.

The Venereal Disease Branch will send a team of four physicians to conduct these seminars.

These men are national leaders in the field of venereal disease control. They will present the latest techniques and methods used for the diagnosis and management of venereal disease as well as discuss research in the various phases of the diagnosis and treatment of these diseases.

Evan W. Thomas, M.D. — Consultant in Venereal Diseases, New York State Department of Health; Emeritus Professor of Clinical Medicine (Syphilology), New York University, College of Medicine; formerly Director of the Syphilis Service at the Bellevue Hospital in New York City, will discuss the management of syphilis in general practice.

Sidney Olansky, M.D. — Research Associate, Duke University School of Medicine, Durham, N. C., will talk on the laboratory tests for syphilis

and their interpretation.

Warfield Garson, M.D. — Director, Venereal Disease Experimental Laboratory, C.D.C., U. S. Public Health Service, Research Professor and Head, Department of Experimental Medicine, School of Public Health, University of North Carolina, Chapel Hill, N. C., will discuss the diagnostic and treatment of gonorrhea.

William J. Brown, M.D., M.P.H. — Chief, Venereal Disease Branch, Communicable Disease Center, U. S. Public Health Service, Atlanta, Georgia, will discuss the necessity of a united front in the control of venereal diseases in the United States.

These four physicians will join local participants on a special panel to discuss the topic "Meeting Today's Venereal Disease Problems."

Never before has it been possible to get so many specialists in this field to come to Arizona and discuss this problem. This seminar will present an opportunity for the physicians in the state to meet and brush up on venereal diseases and to hear of the latest research developments in this field.

Arizona is still rated as a high prevalence venereal disease state. Over 4,000 cases of venereal diseases were reported in the state last year.

Present plans call for the seminar to be held in the Union Building at the University of Arizona in Tucson. This seminar will consist of three meetings, an afternoon session on the 7th and an afternoon and evening session on the 8th. In Phoenix the meeting will be at the main auditorium of the Phoenix Library. There will be an afternoon session on the 9th and an afternoon and evening session on the 10th.

NATIONAL

INTERNATIONAL College of Surgeons — Southeastern regional meeting, Miami Beach, Jan. 4-7, 1959. For information, write to Harold O. Hallstrand, M.D., 7210 Red Road, South Miami, Fla., chairman.

SOUTHWESTERN MEDICAL ASSOCIATION

ANNUAL MEETING

Pioneer Hotel

Tucson, Ariz.

Oct. 23, 24, 25, 1958

Dinner dance Oct. 24

Golf game Oct. 25

High school day visitation, University of Arizona, Oct. 25

Women's special program

Football game, Oct. 25,

University of Arizona vs. Idaho

Regional meetings

You are invited to hear the following speakers:

1. John I. Brewer, M.D. — Professor of Gynecology & Obstetrics, Northwestern University, Chicago, Ill.

2. R. V. Platou, M.D. — Professor and Head of Department of Pediatrics, Tulane University, New Orleans, La.

3. George C. Andrews, M.D. — Consulting Dermatologist to Columbia Presbyterian Medical Center, New York City, N. Y.

4. John W. Henderson, M.D. — Associate Professor of Ophthalmology, Mayo Foundation, Rochester, Minn.

5. Robert M. Zollinger, M.D. — Professor of Surgery, Ohio State University, Columbus, Ohio.

6. Reginald H. Smart, M.D. — Professor of Medicine, University of Southern California, Los Angeles, Calif.

7. John R. Schenken, M.D. — Professor of Pathology, University of Nebraska, Omaha, Neb.

SOUTHWESTERN MEDICAL ASSOCIATION OFFICERS

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Secretary-Treasurer — Russell Deter, M.D., El Paso

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LOCAL COMMITTEES

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Program — James Fritz, M.D., chairman
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 Sherwood Burr, M.D.
 Howard Cogswell, M.D.
 George Fraser, M.D.
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 Clinical motion pictures — Herman Rhu, M.D., chairman
 H. P. Limbacher, M.D.
 Entertainment — Robert Johnson, M.D., chairman
 Jackson Pyre, M.D.
 George Fraser, M.D.
 Women's Activities — Mrs. James N. Lane, chairman

WOMEN'S CONVENTION COMMITTEE

Mrs. James N. Lane — general chairman
 Mrs. Howard Cogswell
 Mrs. Wesley Fee
 Mrs. Ed. Updegraff
 Mrs. F. Shallenberger
 Mrs. John Roads
 Mrs. James Fritz
 Mrs. Louis Hirsch
 Mrs. Elliott Stearns
 Mrs. James Brady
 Mrs. Wright Cortner
 Mrs. Darwin Neubauer
 Mrs. Wesley Soland
 Mrs. Herman Rhu

REGISTRATION:

(Mezzanine, Pioneer Hotel)

Wednesday, Oct. 22 — 9 p.m. until 6 p.m.

Thursday, Friday, Saturday — 8:30 a.m. until 4 p.m.

Registration fee — \$10

(Interns, Residents, Military personnel and Nurses excluded from fee.)

ENTERTAINMENT:

Thursday, Oct. 23

Cocktails and chuckwagon dinner — Desert Willow Ranch

(Bring a jacket or coat — our nights get cool.

Informal wear.)

Friday, Oct. 24

Cocktail hour

(Hosted by Southwestern Surgical Supply Company)

President's dinner

Serenade by Tucson Boys' Choir

Saturday, Oct. 25

Golf, Swimming, Tennis — Tucson Country Club

Football, 8 p.m. — University of Arizona vs. University of Idaho

WOMEN'S ENTERTAINMENT:

Thursday, Oct. 23

Coffee — Roof Garden — 9:30 a.m. - 11 a.m.

University of Arizona tour — 2:30 p.m. - 4:30 p.m.

(Conducted by the University Faculty)

Cocktails and chuckwagon dinner — 6:30 p.m.

(Casual dress — light coat may be needed)

Desert Willow Ranch

Coffee — Roof Garden — 9:30 a.m. - 11 a.m.

Tucson Country Club

Ladies' golf day — 8 a.m.

Tennis and swimming — 10 a.m.

Cocktails and luncheon and style show — 1 p.m. - 3 p.m.

(Around the pool — casual dress)

Style show courtesy of Mills-Touche Mens' Store and

Dorothy Rice

Cocktail party — Host, Southwestern Surgical Supply Company

Presidential dinner

Thursday, Oct. 23, 1958

9 a.m. - 2 p.m. — Registration — Pioneer Hotel

MORNING SESSION

Everett W. Czerny, presiding

9:15 — Invocation — Rev. Jerry Wallace.

9:20 — Welcome — F. J. Lesemann, M.D., president, Pima County Medical Society.

9:30 — President's address — Louis C. Jekel, M.D.

10 — Coffee break.

10:15 — Subject: "The Diagnosis and Treatment of Common Dermatoses of the Hands" — George C. Andrews, M.D., Consulting Dermatologist, Columbia Presbyterian Medical Center, New York, N. Y.

10:45 — Subject: "The Cystic Ovary — Surgical on Non-surgical?" — John R. Schenken, M.D., Professor of Pathology, University of Neb.

11:15 — Subject: "Pelvic Pain" — John I. Brewer, M.D., Professor of Obstetrics and Gynecology, Northwestern University.

11:45 — Subject: "The Surgical Importance of Pancreatitis" — Robert M. Zollinger, M.D., Professor of Surgery, Ohio State University.

Round Table Luncheon Meetings — with discussion of morning papers.

1. Surgery — Robert Zollinger, M.D. Moderator: H. D. Cogswell, M.D.

2. Dermatology. George C. Andrews, M.D. Moderators: Kenneth C. Baker, M.D., and Louis G. Jekel, M.D.

3. Gynecology and Pathology. John L. Brewer, M.D., and John R. Schenken, M.D. Moderators: George Fraser, M.D., and Louis Hirsch, M.D.

AFTERNOON SESSION

2:15 — Business meeting — Golf and films

EVENING

Chuckwagon dinner — Desert Willow Ranch

Friday, Oct. 24, 1958

9 a.m. - 2 p.m. — Registration.

MORNING SESSION

SEMINAR IN PEDIATRICS:

9:20 — Pathology — "Laboratory Diagnosis of Hemolytic Disease of the Newborn and the Selection of the Donor for an Exchange Transfusion in Hemolytic Disease" — John R. Schenken, M.D., Professor of Pathology, University of Neb.

9:40 — Dermatology — "Treatment of Acne" — George C. Andrews, M.D., Consulting Dermatologist, Columbia Presbyterian Medical Center, New York, N. Y.

10 — Gynecology — "Ovarian Lesions During Childhood" — John I. Brewer, M.D., Professor of Obstetrics and Gynecology, Northwestern University.

10:25 — Ophthalmology — "Hemangiomas of Infancy: Eyelids and Orbit" — John W. Henderson, Mayo Clinic.

Visit Exhibits

10:55 — Surgery — "Surgery of the Spleen" — Robert M. Zollinger, M.D., Professor of Surgery, Ohio State University.

11:20 — Internal Medicine — Subject: To be announced — Reginald Smart, M.D., Clinical Professor of Medicine, University of Southern Calif.

11:45 — Pediatrics — Subject: To be announced — Robert H. Lennox, M.D., Associate Professor of Pediatrics, Tulane University.

Round Table Luncheon Meetings — with discussion of morning papers —

1. Pediatrics, Robert H. Lennox, M.D. Moderator: Hugh C. Thompson, M. D.

2. Medicine, Reginald Smart, M.D. Moderator: Clarence L. Robbins, M.S.

3. Ophthalmology, John W. Henderson, M.D. Moderator: Sherwood Burr, M.D.

(The ophthalmologists will have a specialty group meeting Friday morning.) Afternoon: Medical movies and golf. Evening: Complimentary cocktail party and president's dinner.

Saturday, Oct. 25, 1958

MORNING SESSION

Presiding: Leo J. Kent, M.D.

9:15 — "Basic Issues in American Education" — Richard C. Harvill, President, University of Arizona.

10:15 — "Subdural Hematomas in the Elderly" — Peter Stuteville, M.D., Neurosurgeon, University of Colorado.

10:15 — Visit exhibits.

11 — Internal Medicine — "Recognition and Treatment of Respiratory Acidosis" — Reginald Smart, M.D., Clinical Professor of Medicine, University of Southern Calif.

11:30 — Ophthalmology — "The Cataract Patient in General Practice" — John W. Henderson, M.D., Mayo Clinic.

12 — Pediatrics — "Pulmonary Tuberculosis in Childhood" — Robert H. Lennox, M.D., Associate Professor of Pediatrics, Tulane University.

No scheduled luncheon meeting.

The dermatologists will have a specialty group meeting.

AFTERNOON

Golf, Tucson Country Club

EVENING

University of Arizona vs. University of Idaho football game.

VARIDASE* BUCCAL TABLETS

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Controls Inflammation and Swelling...Relieves Pain...
Promotes Healing Through Enhancement of
Fibrinolysis at the Site of Trauma or Infection.

References: 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1089 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 168:478 (Feb. 1) 1958. 3. Davidson, E.; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. 11: 1 (June) 1958 *Reg. U. S. Pat. Off.

In Sinusitis

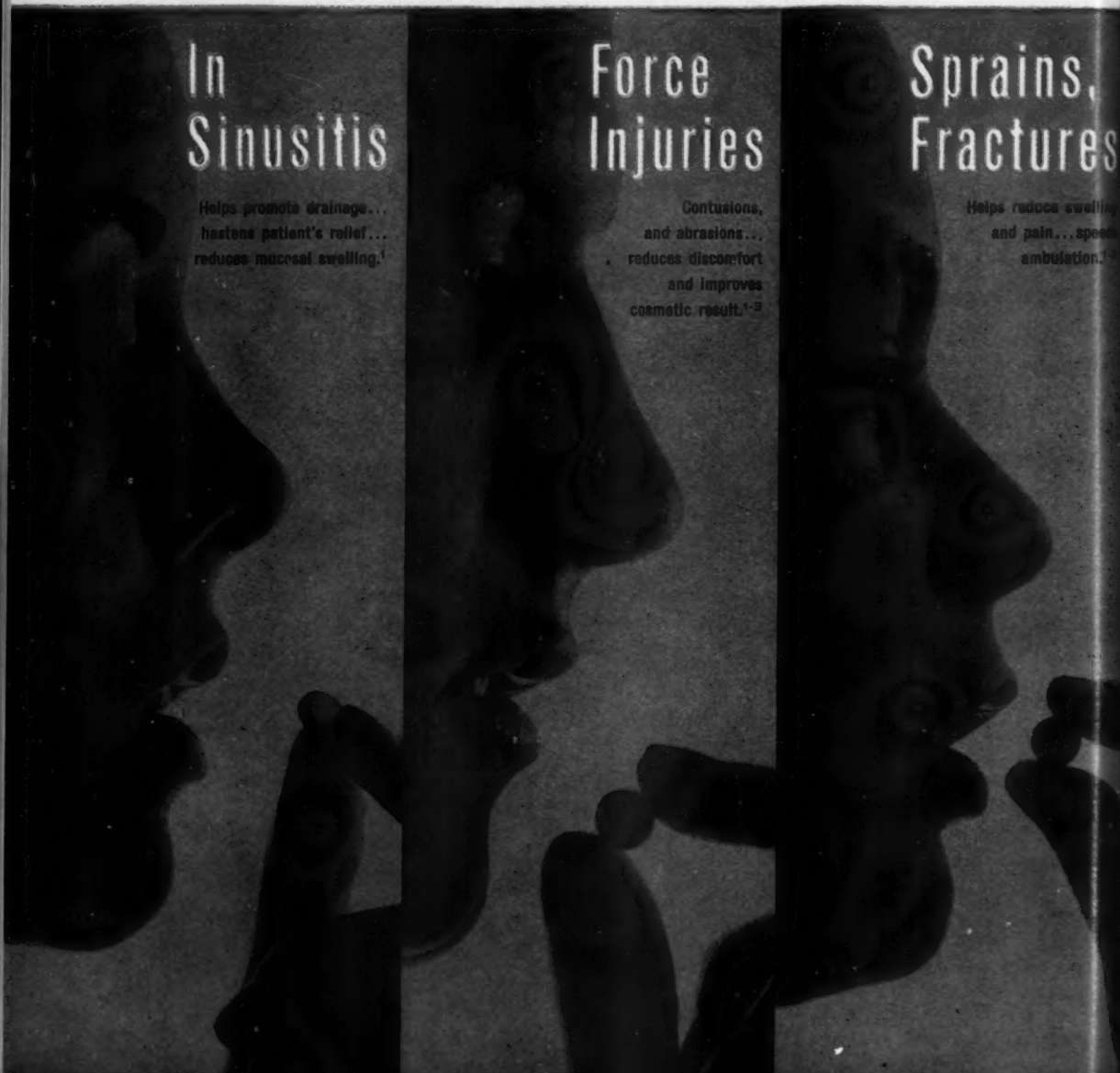
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and abrasions...
reduces discomfort
and improves
cosmetic result.¹⁻³

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Helps reduce swelling
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swelling and
pain... hastens healing.^{1, 2}

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THE MEDICAL SOCIETY OF THE UNITED STATES AND MEXICO

THERE have been direct and indirect reports from Guadalajara on the forthcoming meeting of the Medical Society of the United States and Mexico this coming November, on the 6th, 7th and 8th. Unfortunately, a circular letter announcement to the membership expected from below the border momentarily has not yet been received by press time, although it will probably be in your hands by the time you read this.

Mr. Byron Browder, our avant garde and liaison man in Guadalajara, informs us that a fabulous program is in preparation by the Mexican contingent under the direction and inspiration of Dr. I. Chavez. There will be a substantial and varied scientific program with participants from both countries about equally divided. Lavish entertainment is being planned, sight-

seeing, etc. A special train or railroad car will be provided by the Mexican Southern Pacific from Nogales for this meeting. A preliminary canvassing of American members by the undersigned, showed that a surprisingly large number plan to attend, the greatest proportion signifying their intention to take advantage of the train.

Efforts are being made to take the Tucson Doctors' Orchestra to Guadalajara.

Those interested in joining the society are requested to communicate their wishes to the Mexican treasurer, Dr. Roberto Morfin, Alvarez, Olas Altas 73, Sur, Mazatlan, Sinaloa, Mexico so that he may bill you and place you in the membership and mailing roster.

We anticipate that details concerning reservations for travel and lodging will be contained in the expected circular mentioned above.

JUAN E. FONSECA, M.D.,
Secretary

LA SOCIEDAD MEDICA DE ESTADOS UNIDOS DE NORTEAMERICA Y MEXICO

SE HAN recibido por estas latitudes, informes directos e indirectos procedentes de Guadalajara, tocante a la reunión anual de la Sociedad Medica de Estados Unidos de Norteamérica y México, verificativa del 6 al 9 de noviembre próximo. Lamentamos que a la hora del cierre de esta impresión, no ha llegado a nuestro poder todavía la circular que han de recibir de un día a otro todos los miembros, informándoseles con mas detalles sobre el programa, transporte, etc. Sin embargo, es muy posible que cuando llegue a Ude. este número, ya habrán recibido la tal circular.

El Sr. Byron Browder, nuestro representante de vanguardia en Guadalajara, nos remite entusiásticos comentarios sobre los fabulosos preparativos que están llevando a cabo nuestros anfitriones en Jalisco bajo la tutela e inspiración del Dr. Ignacio Chavez. Se nos promete un programa científico de envergadura, con representantes de ambos países compartiendo las faenas oratorias aproximadamente a partes iguales. Entretenimiento a granel, confeccionado con la

espléndida generosidad de rigor entre los jaliscenses, nos espera. Se proyecta, por parte del Ferrocarril del Sud Pacifico, la organización de un tren especial, o, por lo menos, de un carro exclusivo para los asistentes a la convención, que partirá de Nogales. Un cuestionario preliminar que distribuyó el que suscribe hace poco, reveló que el número de socios y acompañantes que tienen intención de asistir, llega a número crecido; se cuenta, en especial, una gran proporción de adictos al tren.

Se están haciendo esfuerzos por conseguir que asista a la Convención la Arquesta de Médicos de Tucson.

Se recuerda a aquellos que deseen solicitar pertenencia a la Sociedad, que deben comunicarse con el tesorero mexicano: Dr. Roberto Morfin Alvarez, Olas Altas 73, Sur, Mazatlán, Sin., Mex. para que éste pueda pasarle la cuenta para la cuota anual e integrar su nombre a la lista de asociados, de manera que pueda estar al recibo da la correspondencia.

JUAN E. FONSECA, M.D.
Secretario en EE.UU.
2409 E. Adams
Tucson, Ariz.

AMERICAN CANCER SOCIETY ARIZONA DIVISION

Tentative Program
for

The Seventh Annual Cancer Seminar

Jan. 22, 23 and 24, 1959 — Paradise Inn, Phoenix

SEMINAR COMMITTEE

Edward H. Bregman, M.D.

James D. Barger, M.D.

Robert B. Leonard, M.D.

Thursday

9 a.m. — Opening.

9:15 a.m. — "Anemia of Malignant Diseases"

— Dr. Alfred Gellhorn.

10 a.m. — "Relation of Viruses to Cancer" —

Dr. Wendell M. Stanley.

11:15 a.m. — "Recent Advances in Diagnosis and Treatment of Carcinoma of the Cervix" — Dr. Howard Hunt, and Dr. Alexander Brunschwig.

12:30 p.m. — Lunch.

2:30-4:30 p.m. — "Tumors of Central Nervous System" — Dr. James W. Kernohan, Dr. Phillip Hodes, and Dr. Edwin B. Boldrey.

Friday

9 a.m. — Rol Laughner Memorial Lecture — "Treatment of Malignant Disease in the U.S.S.R." — Dr. Alexander Brunschwig.

10 a.m. — "A New Method for Diagnosis of Solitary Lesions of the Lung" — Dr. L. H. Garland.

1:30 a.m. — "Carcinoma of the Lung" — Dr. Richard Overholt, and Dr. W. A. D. Anderson.

12 noon — Annual report — American Cancer Society.

2-4:30 p.m. — Clinical and pathological diagnostic problems — All participants.

Saturday

9 a.m. — "Review of Chemotherapeutic Agents" — Dr. Alfred Gellhorn.

10 a.m. — "Tumors of the Stomach" — Dr. L. H. Garland, Dr. Alexander Brunschwig, and Dr. W. A. D. Anderson.

Saturday afternoon

Nurses' seminar.

THE SOUTHWESTERN SURGICAL CONGRESS

THE 11th annual meeting of the Southwestern Surgical Congress will be held in the Brown Palace Hotel, Denver, Colo., March 30-31, April 1-2, 1959.

THE ARIZONA MEDICAL ASSOCIATION, INC.

THE 68th Annual Meeting of the Arizona Medical Association will be held at the San Marcos Hotel in Chandler, Ariz. on April 28, 29, 30, May 1 and 2, 1959.

TENTATIVE PROGRAM ARRANGEMENTS

Tuesday (April 28)

1 p.m. — Council meeting.

Wednesday (April 29)

9 a.m. — House of delegates — special meeting.

2 p.m. — Blue Shield annual corporation meeting.

6:30 p.m. — Reception — Social hour.

7:30 p.m. — Buffet supper

Thursday (April 30)

8 a.m. — House of delegates — first regular meeting.

9:30 a.m. — General session.

10 a.m. — Scientific session.

2:30 p.m. — Scientific session — Roundtable — Surgical symposium.

6:30 p.m. — Reception — Social hour.

Friday (May 1)

7:30 a.m. — Breakfast (Medical Education Day)

9 a.m. — Medical education program (morning session)

2:30 p.m. — Medical education program (afternoon session)

6 p.m. — Reception — Social hour.

7:45 p.m. — President's dinner-dance.

Saturday (May 2)

8 a.m. — House of delegates — second regular meeting.

10 a.m. — Scientific session.

1 p.m. — Golf tournament — annual handicap.

2:30 p.m. — Scientific session — Roundtable symposium.

It was the consensus of opinion that the only possible way to develop interest among the profession and thereby attract a worthwhile attendance during the annual meeting, restoring an increasing registration which has been diminishing during the past several meetings, is to develop an outstanding scientific program with prominent guest orators participating.

Council has already directed that one full day of the annual meeting be devoted to medical education. Subject to acceptance by the selected participants, it was determined to invite the following:

John W. Cline, M.D. — Past president of AMA, current member of its council on medical education and hospitals, and Associate Clinical Professor of Surgery at Stanford, to serve as moderator.

Thomas B. Turner, M.D., Dean, John Hopkins University, School of Medicine.

Vernon W. Lippard, M.D. — Dean, Yale University School of Medicine.

Roscoe L. Pullen, M.D. — Dean, University of Missouri School of Medicine.

John Z. Bowers, M.D. — Dean, University of Wisconsin Medical School.

Reuben Gilbert Gustavson — President, Resources for the Future, Inc.

Walter L. Hard, Ph.D. — Dean, University of South Dakota.

Marvin E. Johnson, M.D. — Assistant Professor of Surgery, University of Colorado School of Medicine.

Fred Dow Fagg Jr. — President-elect, Western Interstate Commission for Higher Education.

Thomas L. Royce, M.D. — Clinical Assistant Professor in Ophthalmology, Baylor University School of Medicine.

Those who will be invited to participate in the scientific section program for Thursday and Saturday will be:

Haddon Carryer, M.D. — Clinical Section, Mayo Clinic, Rochester, Minn.

Harold Dalton Jenkins, M.D. — Assistant Professor of Medicine, University of Colorado Medical Center.

Henry H. Kessler, M.D., Ph.D. — Kessler Institute for Rehabilitation, Newark, N. J.

Doctors Cline, Johnson and Royce will also participate in the symposiums. Other participants will be announced as may seem indicated.

Specialty Group Luncheon Meetings

With the exceedingly heavy program outlined, together with the possibility that only one noon-day might be available to hold specialty group luncheon meetings, and taking into account the limited space therefor which would necessitate the difficult choosing of no more than four of these groups to be accommodated, it was unanimously determined that such luncheon meetings would be dispensed with in 1959. In substitution therefore, two symposiums will be scheduled, one for Thursday afternoon (April 30) and the other for Saturday afternoon (May 2). It is the hope that selected participants will, to the fullest extent possible, cover the interests of these groups.

LESLIE B. SMITH, M.D.

AMERICAN RHINOLOGIC SOCIETY TO HOLD ANNUAL MEETING

THE AMERICAN Rhinologic Society will hold its fourth annual meeting in the Palmer House, Chicago, Oct. 17-18.

Among the topics to be discussed will be pulmonary and nasal physiology, laboratory and clinical aspects of bone transplants, hump removal, roof repair, and nasal process corrections.

The preliminary program includes the following papers:

"Maxillary and Premaxillary Approach to Septal Surgery," Dr. Ralph H. Riggs, Shreveport, La.

"Olfactory Factors in Experimental Neurosis in Animals," Dr. Jules H. Masserman, Chicago.

"Second Golden Decade of Rhinologic Surgery — The Advances of the Past 10 Years," Dr. Harvey C. Gunderson, Toledo.

"Physiology of Respiration," Dr. David Cugell, Chicago.

"Concepts of Nasal Physiology as Related to Corrective Nasal Surgery," Dr. Maurice H. Cottle, Chicago.

"Bone Transplants; Experimental and Clinical Aspects," Dr. Robert Ray, Chicago.

"Nasal Physiology," Dr. Irving Cramer, Cleveland.

"Hump Removal, Roof Repair, Nasal Process Corrections" will be the subject of a panel. Dr. Walter Loch of Baltimore will be the moderator. The participants will be Drs. Lewis Morrison of Indianapolis, Richard Hadley of Rye, N. Y.; Charles Tucker of Hartford and Joseph West of St. Louis.

The profession is cordially invited to attend as guests. There will be no registration fee.

For further information, write to Dr. Robert M. Hansen, secretary of the society, 1735 N. Wheeler Ave., Portland 17, Ore.

INTERNATIONAL COLLEGE OF SURGEONS POSTGRADUATE COURSE, OCT. 13-25

ANOTHER postgraduate course in surgery will be presented by the United States section of the International College of Surgeons in conjunction with the Cook County Graduate School of Medicine, Chicago, Oct. 13-25.

The course, to be conducted under the supervision of the attending staff of the Cook County Hospital, Chicago, will include illustrated lectures motion pictures, anatomy demonstrations, operative clinics and practice surgery by the participants on anesthetized dogs.

Consideration will be given to an intensive review of the basic sciences in relation to clinical surgery as well as to surgical technique, surgical complications and management of the surgical patient. In addition to 20 hours of surgical anatomy on the cadaver, the program will include lectures and demonstrations on the following:

- Gastric surgery
- Physiology
- Use of blood and derivatives
- Pediatric surgery
- Surgery of large bowel
- Surgery of small bowel
- Intestinal obstruction
- Anorectal surgery
- Surgery of pancreas and spleen
- Gallbladder surgery
- Thoracic emergencies
- Cardiac arrest
- Hand injuries and infections
- Gynecologic surgery
- Surgery of hernia
- Abdominal injuries
- Surgery of the esophagus
- Thyroid surgery

Additional information may be obtained from the International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, or Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 12.

ICS TO PRESENT AROUND-THE- WORLD REFRESHER CLINIC TOUR

THE INTERNATIONAL College of Surgeons will hold its fourth Around-the-World Postgraduate Clinic and Lecture Tour, beginning with departure from San Francisco on Oct. 10. The return to New York will be on Dec. 3.

The itinerary has been carefully planned and, in addition to offering a unique and extremely interesting journey, will afford an opportunity to attend specially arranged surgical clinics and demonstrations in most of the important cities to be visited.

Sections of the College in Hawaii, Japan, Hong Kong, the Philippines, Thailand, India, Egypt, Turkey, Greece, Italy and Spain will be hosts to the visiting surgeons at their clinics and hospitals.

Further information may be had by writing to Dr. Arnold S. Jackson, tour co-ordinator, 16 S. Henry St., Madison 3, Wis., or to the International Travel Service, Inc., 119 S. State St., Chicago 3.

PG COURSE IN OBSTETRICS

THE Woman's Hospital in New York City is offering two courses in obstetrics, limited to general practitioners. Each course is approved for 30 hours Category I credit by the American Academy of General Practice.

The courses are entitled, "Ante-partum Care" and "The Conduct of Labor and Delivery." They will be given from Oct. 16-30, 1958.

These are full time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this post-graduate instruction will please address Mr. Carl P. Wright Jr., Woman's Hospital, 141 West 109th St., New York 25, N. Y., and an application blank and prospectus will be forwarded.

ANNOUNCEMENT FOUR POSTGRADUATE MEDICAL SEMINAR-CRUISES

The cost of attending any of these seminars is a deductible expense when computing income taxes. For information as to deductibility for

income tax purposes of the expenses of professional postgraduate education, see *Journal of American Medical Association*, of July 28, 1956 page 1260 also 1956 edition, *Physicians Income Tax Guide* page 21.

FIRST:

(West Indies-South America)

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE

Nov. 11, 1958, sail from Wilmington, N. C. by the *M/S Stockholm*, 15 days — \$325 up. Visiting Havana, San Blas Islands, Cristobal, Curacao, La Guaira, St. Thomas, and San Juan (with opportunity to visit choice of Merida, Guatemala, Bogota or Lima).

FACULTY:

Charles A. Doan, M.D., Dean and Professor, Department of Medicine; Emmerich von Haam, M.D., Professor and Chairman, Department of Surgery; George J. Hamwi, M.D., Associate Professor, Department of Medicine; Thomas E. Shaffer, M.D., Professor, Department of Pediatrics; Joseph M. Ryan, M.D., Associate Professor, Department of Medicine; Kenneth H. Abbott, M.D., Clinical Assistant Professor, Department of Surgery; and N. Paul Hudson, M.D., Assistant Dean, Postgraduate Medical Education and program chairman.

SECOND:

(West Indies)

KENTUCKY ACADEMY OF GENERAL PRACTICE with a faculty from THE UNI- VERSITY OF LOUISVILLE SCHOOL OF MEDICINE

FACULTY:

Walter S. Coe, M.D., Associate Professor of Medicine and Dean of the Medical Seminar Cruise Faculty; Harry S. Andrews, M.D., Associate Professor of Pediatrics; J. Ray Bryant, M.D., Cardio-Thoracic Surgeon; Ralph M. Denham, M.D., Clinical Instructor in Medicine; J. Herman Mahaffey, M.D., Instructor, Department of Surgery; Robert F. Monroe, M.D., Associate Clinical Professor of Obstetrics and Gynecology; and Carroll L. Witten, M.D., Clinical Instructor in Medicine and registrar and director of the seminar cruise.

THIRD:

NEW YORK UNIVERSITY COLLEGE OF MEDICINE

Feb. 21, 1959, sail from New York by the *M/S*

Italia. Air-conditioned—14 days \$340 up. Visiting San Juan, St. Thomas, Ciudad Trujillo and Nassau.

FACULTY:

William N. Hubbard Jr., M.D., Associate Dean and Assistant Professor of Medicine; William E. Studdiford, M.D., Professor Emeritus, Obstetrics and Gynecology; S. Bernard Wortis, M.D., Professor and Chairman, Department Psychiatry and Neurology; John H. Mulholland Jr., M.D., Professor and Chairman, Department of Surgery; Robert S. Hotchkiss, M.D., Professor and Chairman, Department Urology; Clarence E. de la Chapelle, M.D., Professor of Medicine; William Goldring, M.D., Associate Professor of Medicine; and Saul Krugman, M.D., Associate Professor of Pediatrics.

FOURTH:

(Europe)

DUKE UNIVERSITY SCHOOL OF MED- ICINE FOURTH SEMINAR CRUISE

Jan. 14, 1959, sail from New York by the *M/V Saturnia*, 24 days, anticipated fare, \$1,084 up. (Definite fares will appear in printed literature) Visiting Tangier, Gibraltar, Palma, Palermo, Naples, Rome, Florence, Italian Riviera and Nice.

FACULTY:

Wilburt Cornell Davison, M.D., James B. Duke, Professor of Pediatrics and Dean; William M. Nicholson, M.D., Professor of Medicine and director of post-graduate education; W. Banks Anderson, M.D., Professor of Ophthalmology; Guy L. Odom, M.D., Professor of Neurosurgery; and Julian M. Ruffin, M.D., Professor of Medicine.

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2. Kentucky Academy to the West Indies ☐
3. NYU College of Medicine to the Caribbean ☐
4. Duke University to Europe ☐
(Kindly Print or Type)

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AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

THE SECOND ANNUAL meeting of the American Association of Medical Assistants will take place Oct. 31, Nov. 1 and 2, 1958, at the Palmer House, Chicago, Ill. All medical assistants are cordially invited to attend. We urge each physician to call this meeting to the attention of his assistant.

PROGRAM

Friday, Oct. 31:

- 8-10 a.m. — Registration.
- 8-9 a.m. — House of delegates meeting.
- 9-11 a.m. — General business session.
(Welcome by Dr. F. J. L. Blasingame, executive vice president of the American Medical Association)
- 11-12 noon — Advisors' symposium.
Leo J. Starry, M.D., moderator.
"The Value of This Association to Doctors"
— Fred Sternagel, M.D.
"Office Assistants and Blue Shield" — Robert L. Schaeffer, M.D.
"Professional Ethics" — Frederick H. Falls, M.D.
"Jobs Delegated to Medical Assistants" — Murray C. Eddy, M.D.
- 2 p.m. — Board buses for AMA building.
- 2:30-5 p.m. — Tour of AMA building and program in their auditorium.
Speakers, films and exhibits to be furnished by AMA)
- 6-7 p.m. — Social hour.
- 7 p.m. — Dinner.
Lucille Swearingen, presiding. Speaker — Morris B. Fishbein, M.D.

Saturday, Nov. 1:

- 8 a.m. — House of delegates meeting—Election
Three special sections listed under "Business," "Technical," and "Medical." Three rooms will be in use at the same time with a medical assistant manning each one. Girls may choose subjects in which they are especially interested, and go to these rooms. Rooms will be fully equipped with latest office machines, laboratory equipment and office furniture.

ROOM I — BUSINESS

- 9-9:30 a.m. — Insurance (Daniel C. McKay, the Paulsen Insurance Co.)
- 9:45-10:15 a.m. — Office machines (Colorado MA presiding.)
- 10:30-11 a.m. — Credit (Maynard L. Heacox,

Medical-Dental Hospital Bureaus of America.)

11:15-11:45 a.m. — Records — Forms (Colwell Publishing Co., etc.)

3:30-4 p.m. — Telephone techniques (Illinois Telephone Co.)

4:15-4:45 p.m. — Banking (Raymond S. Blunt Sr., CPA.)

ROOM II: MEDICAL

9-9:30 a.m. — Emergencies (Missouri MA).

9:45-10:15 a.m. — Medicolegal problems (George Hall, AMA).

10:30-11 a.m. — Case histories — Pertinent Information (Michigan MA.)

11:15-11:45 a.m. — Good housekeeping and personal grooming (Texas MA — 2.)

3:30-4 p.m. — Civil defense and how we can help (Harold Lueth, M.D., FCDA, Medical Consultant, Health Division, Operations Service.)

4:15-4:45 p.m. — Public relations (Jerry Harris, Medical Arts Division of Creditors' Bureau, El Paso, Texas.)

ROOM III — TECHNICAL

9-9:30 a.m. — New Laboratory Procedures (Mr. A. Coldiron and Iowa MA)

9:45-10:15 a.m. — New Developments in X-ray (Robert G. Morris Jr., M.D.)

10:30-11 a.m. — Inner Office Professional Ethics (California MA.)

11:15-11:45 a.m. — ECG, Ultrasonic and Diathermy (Herbert Levinger, A. S. Aloe Co.)

3:30-4 p.m. — Aseptic Techniques (Wisconsin MA.)

4:15-4:45 p.m. — What is Good Practice for the Physician and Medical Assistant? (Raleigh Oldfield, M.D., president, Illinois Medical Society.)

GENERAL SESSION

2-3:20 p.m. — "Go and Do Likewise" — Harold Scherer, business manager, Monroe Clinic, Monroe, Wis.

"Is The Welcome Mat Out?" — I. D. Harvey, divisional sales manager, Abbott Laboratories, North Chicago, Ill.

6-7 p.m. — Social hour and reception.

7 p.m. — Banquet and installation of officers.

Presiding: Mary Kinn, president, American Association of Medical Assistants.

Master of Ceremonies: Robert J. Samp, M.D., Director of Tumor Clinic, University Hospitals, Madison, Wis.

Sunday, Nov. 2:

10-12 noon — Sunday morning brunch

Farewell from Chicago and an invitation to

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Duodenal Ulcer
before PATHIBAMATE



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Hotel reservations should be made directly with: Palmer House, Chicago, Ill.

Rates: Singles — \$8 - \$16, doubles — \$14.50 - \$20, twins — \$15.50 - \$22. No deposit necessary.

Registration fee of \$18 includes: Friday: Tour

of the American Medical Association building, program in their auditorium, and transportation from and return to hotel.

Friday: Dinner in the Red Lacquer Room.

Saturday: Cocktail party and banquet—Grand Ballroom.

Sunday morning: Brunch.

POSTGRADUATE COURSES

to be presented by

**THE UNIVERSITY OF TEXAS
 SOUTHWESTERN MEDICAL SCHOOL**
Dallas 19, Texas
 1958-59

PHYSICIANS:

Ear, Nose and Throat — Oct. 3 and 4, 1958.
 Orthopedic Surgery — Oct. 30, 31 and Nov. 1, 1958. Psychiatry — Nov. 3, 4, and 5, 1958. Pulmonary disease (Mattson seminar) — May 22

and 23, 1958. The Stomach and bowel — June 25, 26, and 27, 1959.

ASSOCIATED PERSONNEL:

Social workers (emphasis on geriatrics)—Oct. 17 and 18, 1958. Dietitians (emphasis on pediatrics) — Dec. 5 and 6, 1958. Technologists (bacteriology) — Feb. 27 and 28, 1959.

DALLAS SOUTHERN CLINICAL

March 23-25, 1959

Annual spring conference

CALENDAR OF MEETINGS

DATE	MEETINGS	PLACE
Sept.		
29-31	Soc. of Clinical & Exper. Hypnosis	Chicago, Ill.
30 - Oct. 3	American Roentgen Ray Society	Shoreham Hotel, Washington, D.C.
Oct.		
2	Arizona Academy of General Practice	Scottsdale, Arizona
5-10	American College of Surgeons	Chicago, Ill.
9-10	Big 12 Cities Meeting	Biltmore Hotel, N.Y.C.
10 - Dec. 3	International Coll. of Surgs. 3rd Around the World post graduate clinic tour	
13-15	Natl. Rehabilitation Ass'n. Annual Meeting	Ashville, N. C.
20-24	Annual Meeting Amer. Cancer Soc. (Sci. Sess.)	Biltmore Hotel, N.Y.C.
23-25	Southwestern Medical Association	Tucson, Ariz.
23-25	Course in PG Gastroenterology — Amer. Coll. Gastroenterology	Jung Hotel, New Orleans, La.
27-31	American Public Health Association	St. Louis, Mo.
Nov.		
2-8	American Society Clinical Pathologists	Chicago, Ill.
2-8	6th International American Congress Radiology	Lima, Peru
3-8	College American Pathologists	Chicago, Ill.
5-8	Med. Soc. of the U. S. and Mexico	Guadalajara, Mexico
10-13	American Dental Association	Dallas, Texas
17-22	Radiological Society of North America	Chicago, Ill.
18-22	Pan American Dental Congress	Mexico City, Mexico
Dec.		
2-5	American Med. Ass'n. Clinical Meetings	Minneapolis, Minn.

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Woman's Auxiliary

REPORT OF THE NATIONAL CONVENTION — SAN FRANCISCO

Mrs. Melvin W. Phillips, President

SAN Francisco opened its cosmopolitan heart to embrace some 43,000 persons concerned with the 1958 AMA annual meeting, the 10th such meeting to be held in that city in 90 years. Of that number, 2,146 doctors' wives registered for the 35th annual meeting of the Women's Auxiliary to the AMA with headquarters in the Fairmont Hotel situated atop a frequent hill, cooled by the usual summer breezes, and warmed by the unusually prevailing sunshine which brightened the entire week of June 23. Additional sunshine was provided by the California hostesses who anticipated our comforts, interests and entertainment to frost the convention cake.

In addition to the president, Arizona delegates included Mesdames: Hiram Cochran, president-elect, Tucson; Jesse Hamer, George Enfield, and George McKhann, of Phoenix. The delegates attended round-table discussions covering all phases of the auxiliary program in addition to the three-day general meeting of the house of delegates.

The national president praised the mood of the meeting as the following was accomplished:

1. The constitution and by-laws were completely revised into one set of national by-laws.
2. The incorporation of the Woman's Auxiliary to the AMA was approved.
3. The revised report forms were approved.
4. Chairmen of state advisory committees and state executive secretaries were entertained at an appreciation luncheon honoring them as well as AMA officers and trustees.
5. A retirement plan was approved for employees of the national auxiliary.
6. A 1957-58 total of \$126,009.91 was reported contributed to the American Medical Education Foundation.

Changes

By-law changes included substituting 300 for 100 constituent auxiliary members on which to base state representation providing that each state shall be entitled to at least one voting delegate in addition to the president. This change is designed to make the house of delegates a more wieldy group and cuts Arizona's official

delegation quota from six to two plus the president. Other changes include terminology: Recruitment is now called "paramedical careers recruitment"; and public relations are now referred to as "community service."

A proposed budget of \$76,000 was accepted substantiating the magnitude of this organization. A proposed change in records for treasurers and membership cards was approved by an appraisal committee, and county treasurers should have information by September.

Arizona was named second runner-up in AMEF contributions with \$2.38 per capita giving. The highest contribution was \$8.98 per capita.

Tense excitement sparked interest at several points including the election of officers as issues were decided by official ballots.

Mrs. Joseph M. Greer was among those honored by an impressive memorial service remembering auxiliary members who died during '57-'58.

Guest speakers included Richard H. McFeely, principal, George School, Bucks County, Pa., who showed a warm approach to the problems of young people and expressed hope for the future through world-wide understanding.

Speakers

Dr. David B. Allman, immediate past-president of the AMA, was introduced by Mrs. Hamer, former national auxiliary president, and spoke of the importance of women understanding the reasons why others outside the profession may think adversely, and urged that techniques of communications be brought to bear in creating good will.

S. I. Hayakawa, Ph.D., educator, lecturer, and writer, presented an outstanding interpretation of "Language as an Influence on Human Behavior," exemplifying psychological theory, transactional psychology, or more commonly called communications.

Dr. Ernest B. Howard, assistant secretary, AMA, presented the AMA Round-up summarizing the doctors' convention and indicating in which matters the auxiliary members will probably be requested to participate. Legislation is among the foremost with the Forand bill still getting priority.

In her inaugural address, Mrs. E. Arthur Underwood stressed truth and principle above all and promoted a year of *action*: AMEF, Communications, Today's Health, individual service and responsibility, others through recruitment, and *now!*

The convention observers' report indicated

that members were interested in hearing less from national chairmen and more from state presidents. It was my pleasure to use the allocated two minutes to present a sampling of our state activity and, as your official delegate, represented Arizona with great pride.

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Jan. 1959		
4-7	Southeastern Regional Meeting International Coll. of Surgeons	Miami, Fla.
Feb.		
5-8	American Coll. of Radiology, Annual Meeting	Chicago, Ill.
March		
9-12	AMA 4-day Sectional Meeting	St. Louis, Mo.
16-20	National Health Council Annual Meeting	Chicago, Ill.
30 - Apr. 2	Southwestern Surg. Congress	Denver, Colo.
April		
6-8	American Radium Society	Homestead Hotel, Hot Springs, Va.
6-9	American Academy of General Practice	San Francisco, Calif.
9-12	American Ass'n. for Cancer Research Inc.	Haddon Hall, Atlantic City, N. J.
20-23	American Ass'n. Pathologists & Bacteriologists	Boston, Mass.
20-24	American College of Physicians	Conrad Hilton Hotel, Chicago, Ill.
28 - May 2	Arizona Medical Association	Chandler, Ariz.

DRUGS: Their Nature, Action and Use
by Harry Beckman, M.D. 728 pages. Illustrated. (1958) Saunders. \$15.

The director of the Department of Pharmacology, Marquette, grouping his drugs by their action, includes the most important ones, with notations on indications, contraindications, dosages, toxicity, and side effects. The many users of "Beckman" will be pleased to find here again the author's lucid and personal writing style.

Stacey's Medical Books, San Francisco, California.

FRACTURES AND RELATED INJURIES
by J. Grant Bonnin, M.D. 710 pages. Illustrated. (1958) Grune & Stratton. \$12.75.

An important addition to the many books on fracture is complete and practical for those who want a single volume, and also presents a new perspective for those with several volumes. Numerous admirable illustrations reduce the need for descriptions. The author has cut to the bone both figuratively and literally. The reviewer can do no less: It is good.

Stacey's Medical Books, San Francisco, California.

**CLINICAL HEART DISEASE
TEXTBOOK OF VIROLOGY**
by A. J. Rhodes, M.D., and C. E. van Rooyen, M.D. 3rd ed. 642 pages. Illustrated. (1958) Williams & Wilkins. \$10.

The new edition, over twice the size of the first edition in 1949, has come a long way. Both virology and the authors, Canadian experts, have

come into their own during the interval. The book now covers the accepted portions of virology well and in conservative and readable fashion. The authors keep their goal realistically in mind — to provide a graduate text which will also assist physicians who now have diagnostic laboratory services available in many places. Calm, orderly, and current, this book has no present peer.

Stacey's Medical Books, San Francisco, California.

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